PART 1
HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

H.R. 10460

A BILL TO AMEND TITLES XV AND XVI OF THE PUBLIC HEALTH SERVICE ACT TO REVISE AND EXTEND THE AUTHORITIES AND REQUIREMENTS UNDER THOSE TITLES FOR HEALTH PLANNING AND HEALTH RESOURCES DEVELOPMENT

JANUARY 30, 31, FEBRUARY 1, AND 2, 1978

Serial No. 95–93



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Halper, Robert, general counsel.
Johnson, Gifford, president.
American Dental Association:
Bishop, Eric, assistant executive director for dental health.
Kerr, I. Lawrence, D.D.S., member, board of trustees.
American Federation of Labor and Congress of Industrial Organizations:
McGlotten, Robert, legislative representative, department of legislation.
Siedman, Bert, director, department of social securtiy.
Shoemaker, Richard, assistant director, department of social security.
American Health Planning Association:
Hanson, Jacqueline B., treasurer.
Matek, Stanley J.
American Hospital Association:
Gehrig, Leo J., senior vice president.
McMahon, John Alexander, president.
American Medical Association:
Hill, Dan. assistant director, legislative department.
Jirka, Frank J., M.D., vice chairman, board of trustees.
Johnson, Archie T., M.D., ad hoc Committee on Planning.
Peterson, Harry N., director, legislative department.
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Perin, John P., director, Washington office.
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Cooper, Gerson I., chairman, Government relations committee.
Doody, Michael, F., president.
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Everhart, David, on behalf of.
Association of State and Territorial Health Officials, Arthur Y. Webb, on behalf of.
Birmingham Regional Health Systems Agency, Inc., Albert H. Rohling, executive director.
Blue Cross Association, Neil Hollander, vice president.
Central Georgia Health Systems Agency, Don Trantow, executive director.
Central Northeast Colorado Health Systems Agency, Anne Fenerty on behalf of.
Champaign County (Illinois) Health Care Consumers, Barry Checkoway, on behalf of.
Consumer Coalition for Health, Herbert Semmel, president.

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Federation of American Hospitals:
Bromberg, Michael D., executive director.
Samsel, Robert J., president.
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Biskind, Eve.
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Health Insurance Association of America, Henry A. DiPrete, on behalf of.
Health Planning Council of the Eastern Shore, Inc.:
Dierks, Fred, executive director.
Parr, Col. Bertram (USA Ret.), vice president.
Homemakers Upjohn, Budd J. Norris, president.
Hospital Financing Study Group:
Greene, Thomas III.
Quinn, Thomas H., general counsel.
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Lane, James A., vice president and counsel.
Newman, H. Frank, M.D., vice president.
Medical Society of Virginia, William J. Hagood, Jr., M.D., president.
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Michigan Hospital Association, Leo Greenawalt, vice president for governmental affairs.
Mid-America Regional Council, Peter Levy, executive director.
National Association of Counties, Mike K. Gemmell, associate director for health and education.
National Association of Regional Councils, Roger L. Smith, on behalf of.
National Association of Single State Agencies, Richard Neibaur, chairman.
National Conference of State Legislatures, Hon. Elaine Gordon (Florida State representative).
National Congress of American Indians:
Carmady, Theresa, on behalf of.
Press, Daniel, counsel.
National Council of Senior Citizens, Einar Mohn, on behalf of.
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National Indian Health Board, Inc., Theresa Carmady, on behalf of.
Northern California Association of Health Systems Agencies, Art Gilman, chairman.
Public Citizens Health Research Group:
Bogue, Ted, attorney.
Wolfe, Sidney, M.D., director.
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Hoskins, Dorothy, president.
Meyer, Dave, executive director.

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

MONDAY, JANUARY 30, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:15 a.m. in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

This morning the subcommittee begins 4 days of hearings on H.R. 10460, the Health Planning and Resources Development Amendments of 1978, and other proposals designed to extend and amend titles XV and XVI of the Public Health Service Act.

The National Health Planning and Resources Development Act of 1974, Public Law 93–641, provided for the development of a structure to plan for a health system that will provide our citizens with access to quality health services at reasonable cost.

The purpose of these hearings is to examine that structure and the progress being made to put it in place. We are also interested in learning how well the planning system is working, although our expectations must be tempered by the fact that most health systems agencies are less than 2 years old and much of that short time has been spent on organizational matters.

I believe that the health planning structure created by Public Law 93641 is sound. Yet we must work to find ways to improve and strengthen it. We must do this in a way that is designed to provide as little disruption to the planning system as possible, recognizing the great time and effort that has been expended by volunteers, both consumers and providers, in developing it.

There has already been some national level discussion of health planning in the context of the national health planning guidelines proposed by the Department of Health, Education, and Welfare. I am pleased with the revisions in the guidelines which the Secretary announced on January 18, 1978. They respond to both congressional concerns and the concerns raised by many individuals and groups about these proposed guidelines by making it clear that decisions about the adequacy of health services will be made at the local level.

However, that discussion highlighted some of the basic difficulties we face in medical care. It is easy to support principles which lead to more reasonable health care costs for our citizens and to more efficient health care delivery systems, yet very difficult to make tough decisions about unneeded health care facilities or services that add to health care cost and system inefficiency. Yet such decision-making is central to sound health planning.

While there are many issues that will surface during the course of our hearings, I believe there are six issues that will be most central to our discussion of the extension and amendment of this law.

First: There is a need to examine the adequacy of the health systems agencies governing body requirements of the law.

Second: The role of the State in the health planning structure deserves careful review.

Third: Consideration must be given to strengthening the linkage between the planning required at the State and local levels and the planning that should be occurring at the national level.

Fourth: There is a need to examine the adequacy of the certificate of need and other review requirements of the law.

Fifth: Consideration must be given to how to deal with existing unneeded and duplicative health facilities and services.

And, finally, we must provide that funding for the planning system will be adequate.

As we begin our hearings, I look forward to many constructive suggestions on these and other issues to improve the health planning system.

Dr. Carter, I think you have a statement.

Mr. Carter. Thank you, Mr. Chairman.

As you know, I have long supported improvements in health planning. I have done so because I believe that a strong health planning system is our most important weapon in our attempts to successfully constrain the rising costs of health care.

Moreover, I believe that health planning is the key to providing the necessary improvements in health care which the American people deserve. For this reason, I would contend that the task before this subcommittee is to do all that we can to assist the efforts of State and local health planners. These planners are charged with implementing a complex piece of legislation, and I believe that they should be commended for their efforts to date. Progress has been made, even though necessary guidelines and regulations have not been issued by HEW in a timely fashion. I hope that we can explore the reasons for this during these hearings.

I would also like to point out that the health planning system is in its infancy, and therefore, I would suggest that we proceed cautiously in either altering the procedures of the system, or in adding new duties to it.

One thing is clear, the problems of excess capacity and duplication of resources have been with us for some time and we are not going to solve these problems overnight. I know that many suggestions for changing the Health planning Act have been made, and I look forward to a full discussion of those suggestions during these hearings,

but we must keep in mind that each change we make here impacts upon many people across this country who are presently working hard to make a health planning system a reality.

We can do no less than to give them our fullest support.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

Without objection, the text of H.R. 10460 will be printed in the record.

[Testimony resumes on p. 52.]

[The text of H.R. 10460 follows:]

95TH CONGRESS
2D SESSION

H. R. 10460

IN THE HOUSE OF REPRESENTATIVES

JANUARY 19, 1978

Mr. ROGERS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCES TO PUBLIC HEALTH SERVICE ACT; AND TABLE OF CONTENTS

SECTION 1. (a) This Act may be cited as the "Health Planning and Resources Development Amendments of 1978".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

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TITLE I—ONE-YEAR EXTENSION

Sec. 101. One-year extension.

TITLE II—REVISION OF HEALTH PLANNING AUTHORITY

Sec. 201. Revision and reporting on national guidelines for health planning.
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Sec. 203. Designation of health service areas.
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TITLE I—ONE-YEAR EXTENSION

ONE-YEAR EXTENSION

SEC. 101. (a) Section 1516(c)(1) is amended by striking out "and" after "1977," and by inserting before the period ", and September 30, 1979".

(b) Section 1525(c) is amended by striking out "and" after "1977," and by inserting before the period ", and September 30, 1979".

(c) Section 1526(e) is amended by striking out "and" after "1977," and by inserting before the period ", and September 30, 1979".

(d) Section 1534(d) is amended by striking out "and" after "1977," and by inserting before the period ", and September 30, 1979".

(e) Section 1613 is amended by striking out "and" after "1977," and inserting before the period ", and September 30, 1979".

(f) Section 1640(d) is amended by striking out "and" after "1977," and by inserting before the period ", and September 30, 1979".

TITLE II—REVISION OF HEALTH PLANNING AUTHORITY

REVISION AND REPORTING ON NATIONAL GUIDELINES FOR HEALTH PLANNING

SEC. 201. (a) Section 1501 is amended (1) by striking out "and shall, as he deems appropriate, by regulation revise such guidelines" in subsection (a), and (2) by adding after subsection (c) the following:

"(d) The Secretary shall, on an annual basis, review the standards and goals included in the guidelines issued under subsection (a). In conducting such a review, the Secretary shall review the health systems plans and annual implementation plans of health systems agencies and State health plans. If the Secretary proposes to revise a guideline issued under subsection (a), he shall make such revision by regulations promulgated in accordance with section 553 of title 5, United States Code.

"(e) (1) The Secretary shall collect data to determine whether the health care delivery systems meet or are changing to meet the standards and goals included in the guidelines issued under subsection (a) and to determine the personnel, facilities, and other resources needed to meet such standards and goals. The Secretary shall prescribe the manner in which such data shall be assembled and reported to the Secretary by health systems agencies, State health planning

and development agencies, and other entities and the definitions which shall be used by such agencies and entities in assembling and reporting such data.

"(2) The Secretary shall periodically make public from the data collected under paragraph (1) a (A) statement of the relationship between such standards and goals and the status of the supply, distribution, and organization of health resources with respect to which such standards and goals were established, and (B) summary of changes (either through additions or reductions) in resources needed to meet such standards and goals.".

(b) (1) Section 1513(b) (1) is amended by adding after and below subparagraph (F) the following:

"The agency shall also assemble and report to the Secretary such data (including data on the personnel, facilities, and other resources needed to meet the goals set forth in the agency's health system plan) as the Secretary may require to carry out his responsibilities under section 1501(e).".

(2) Section 1522(b) (10) is amended by inserting "(A) assemble and report to the Secretary such data (including data on the personnel, facilities, and other resources needed to meet the goals set forth in the State health plan) as the Secretary may require to carry out his responsibilities

under section 1501(e), and (B)" after "require the State agency to".

NATIONAL HEALTH PRIORITIES

SEC. 202. Section 1502 is amended by adding at the end the following:

"(11) The discontinuance of duplicative or unneeded services and facilities.

"(12) The adoption of policies which will (A) contain the rapidly rising costs of health care delivery, (B) insure more appropriate use of health care services, and (C) promote greater efficiency in the health care delivery system.".

DESIGNATION OF HEALTH SERVICE AREAS

SEC. 203. (a) The first sentence of section 1511(b)(4) is amended by inserting after "the requirements of subsection (a)" the following: "or a change in the boundary of such area would result in a health service area which better meets the requirements of such subsection".

(b) Section 1511(c) is repealed.

DESIGNATION OF HEALTH SYSTEMS AGENCIES

SEC. 204. (a) Section 1515(b)(4) is amended by striking out the last sentence and inserting in lieu thereof: "In considering such applications, the Secretary shall give priority to any application which has been recommended by a Governor for approval. When the Secretary enters

into an agreement with an entity under paragraph (1), the Secretary shall notify the Governor of the State in which such entity is located of such agreement.".

(b) The last sentence of section 1515(c)(2) is amended to read as follows: "In considering such applications, the Secretary shall give priority to any application which has been recommended by a Governor for approval.".

(c) Section 1515(c) is amended by adding after paragraph (4) the following:

"(5) Before renewing an agreement with a health systems agency under this subsection, the Secretary shall provide the State health planning and development agency of the State in which the health systems agency is located an opportunity to comment on the performance of such agency and to provide a recommendation on whether such agreement should be renewed and whether its renewal should be made subject to conditions as authorized by paragraph (3).

"(6) If the Secretary enters into an agreement under this subsection with an entity or renews such an agreement, the Secretary shall notify the Governor of the State in which such entity is located of the agreement, its renewal, and, if any conditions have been imposed under paragraph (3), such conditions.".

LIMITS ON DESIGNATED AGENCIES

SEC. 205. Section 1515(c)(3) is amended by adding at the end thereof the following: "If the Secretary determines that a health systems agency has not so fulfilled such functions or does not continue to meet such requirements, the Secretary may renew a designation agreement for such agency under such conditions as the Secretary determines appropriate, including conditions which limit the functions which the agency would be authorized to perform or the amount the agency may receive under a grant under section 1516.".

PLANNING GRANTS

SEC. 206. (a) Section 1516 is amended by redesignating subsection (c) as subsection (d) and by striking out subsection (b) and inserting in lieu thereof the following:

"(b) The amount of any grant under subsection (a) to a health systems agency designated under section 1515 (b) shall be determined by the Secretary.

"(c)(1) Except as provided in paragraphs (2) and (3), the amount of a grant under subsection (a) to a health systems agency designated under section 1515(c) shall be the greater of the amount determined under subparagraph (A), (B), or (C) as follows:

"(A) The amount of a grant to a health systems agency shall be the lesser of—

"(i) if the population of the health service area for which the agency is designated—

"(I) is not over one million, the product of $0.70 and the population of such area,

"(II) is over one million but not over two million, the sum of $700,000 and the product of $0.50 and the population of such area which is over one million, or

"(III) is over two million, the sum of $1,200,000 and the product of $0.30 and the population of such area which is over two million, or

"(ii) $3,750,000.

"(B) (i) If the application of the health systems agency for such grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of clause (ii) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

"(I) the amount determined under subparagraph (A) or (C), whichever is applicable, and

"(II) the lesser of the amount of such non-Federal funds with respect to which the assurances were made, or the product of $0.25 and the population of the health service area for which the agency is designated.

"(ii) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by clause (i) shall—

"(I) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

"(II) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

"(C) The amount of a grant to a health systems agency may not be less than—

"(i) $200,000 in the case of a grant made in the fiscal year ending September 30, 1980,

"(ii) $215,000 in the case of a grant made in the fiscal year ending September 30, 1981, and

"(iii) $230,000 in the case of a grant made in any succeeding fiscal year.

"(2) The amount of a grant to a health systems agency which is subject to a condition imposed by the Secretary under section 1515(c)(3) shall be determined in accordance with such condition.

"(3) If the Secretary determines, after review of the budget of a health systems agency, that the amount of a grant which is to be made to the agency in accordance with paragraph (1) is in excess of the amount needed by the agency to adequately perform its functions under its designation agreement, the amount of the grant to the agency shall be such amount as the Secretary determines the agency needs for the performance of such functions.".

(b) Subsection (d) (as so redesignated) is amended by striking out paragraph (2) and inserting in lieu thereof the following:

"(2) Of the amount appropriated under paragraph (1) for any fiscal year, the Secretary may use not more than 10 per centum of such amount to increase the amount of a grant in such fiscal year to a health systems agency under

subsection (a) to assist the agency in meeting extraordinary expenses (including extraordinary travel expenses and expenses resulting from the agency's health systems area being located in more than one State) which would not be covered under the amount of the grant that would be available to the agency under subsection (c).

"(3) Notwithstanding subsection (c) (1), if the total of the grants to be made in any fiscal year to health systems agencies designated under section 1515(c) exceeds the total of the amounts appropriated under paragraph (1) for such grants in such fiscal year (reduced by the amount retained by the Secretary for use under paragraph (2)), the amount of the grant to be made in such fiscal year to each such health systems agency which but for this paragraph would have its grant amount determined under subparagraph (A) or (B) of subsection (c) (1) shall be an amount which bears the same ratio to the grant amount prescribed for such agency in such fiscal year by such subparagraph as the total of the amounts appropriated under paragraph (1) for that fiscal year (as so reduced) bears to the total amount required to make grants to all such agencies in accordance with subparagraphs (A) and (B) of subsection (c) (1).".

(c) The second sentence of section 1516(a) is amended

by inserting "(including submission of the health systems agency's budget)" after "such conditions".

CARRYOVER OF GRANT FUNDS

SEC. 207. (a) (1) The second sentence of section 1516(a) is amended by striking out ", and shall be available for obligation" and all that follows in such sentence and inserting in lieu thereof a period.

(2) Such section is amended by inserting after the second sentence the following: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to an agency may be obligated in any period in which a designation agreement is not in effect for such agency.".

(b) The second sentence of section 1525(a) is amended to read as follows: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for such State Agency.".

(c) Section 1526(c) is amended (1) by striking out

"(1) such a grant" and all that follows through "(2)", and by inserting at the end the following: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for such State Agency.".

LOCAL FINANCIAL SUPPORT OF HEALTH SYSTEMS AGENCIES

SEC. 208. (a) The first sentence of section 1512 (b) (5) is amended by striking out "it is" and inserting in lieu thereof "it is a health care insurer or it is".

(b) Section 1516 (b) (2) (B) (i) is amended by inserting after "health resources" the following: "unless it is an entity which is a health care insurer".

MEMBERSHIP REQUIREMENTS

SEC. 209. (a) (1) Section 1512 (b) (3) (C) (i) is amended by inserting "(including labor organizations)" after "major purchasers of health care".

(2) The first sentence of section 1512 (b) (3) (C) (ii) is amended (A) by striking out "residents of" and inserting in lieu thereof "residents of, or have their principal place of business in,", and (B) by striking out "and (V)" and inserting in lieu thereof ", (V)" and by inserting before the

period a comma and the following: "and (VI) indirect providers of health care as defined in section 1531(3)".

(b) (1) Section 1512(b) (3) (C) (iii) is amended by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively, and by striking out subclause (I) and inserting in lieu thereof the following:

"(I) include (either through consumer or provider members) public elected officials and other representatives of general purpose local governments in the agency's health service area.

"(II) include representatives of public and private agencies in the area concerned with health,".

(2) Subclause (III) (as so redesignated) of such section is amended (A) by striking out "is equal" and inserting in lieu thereof "is at least equal", and (B) by striking out "and" at the end.

(3) Such section is amended by striking out subclause (IV) (as so redesignated) and inserting in lieu thereof the following:

"(IV) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as a nonvoting, ex officio member, an individual whom the

Chief Medical Director of the Veterans' Administration shall have designated for such purpose,

"(V) if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.".

(4) Section 1524(b)(1)(D) is amended by striking out "an ex officio" and inserting in lieu thereof "a nonvoting, ex officio".

(c) Section 1512(b)(3)(C) is amended by inserting after and below clause (iv) the following:

"A member of a governing body or other entity appointed pursuant to clause (iii)(IV) shall not be considered in determining if the requirements of clauses (i), and (ii) have been complied with.".

(d)(1) Section 1512(b)(3)(C)(i) is amended by striking out "who are not (nor within the twelve months preceding appointment been) providers of health care" and inserting in lieu thereof "who are not providers of health care and have not within the twelve months preceding appointment been direct providers of health care (as defined in section 1531(3)(A))".

(2) Section 1531(3)(B)(iii) is amended by striking out "is a member of the immediate family of" and inserting in lieu thereof "is the spouse of".

GOVERNING BODY SELECTION

SEC. 210. Section 1512(b)(3) is amended by adding after subparagraph (C) the following new subparagraph:

"(D) SELECTION.—Each health system agency shall establish a process for the selection of the members of its governing body which process is designed to assure that (i) such members are appointed in acccordance with the requirements of subparagraph (C), (ii) there is the opportunity for broad participation in such process by the residents of the health service area of the agency, and (iii) the participation of such residents will be encouraged and facilitated. Such process shall prohibit the governing body from selecting its members. Each agency shall make public such process and report it to the Secretary.".

RESPONSIBILITIES OF GOVERNING BODIES

SEC. 211. (a) Section 1512(b)(3)(B)(i) is amended to read as follows:

"(i) shall be responsible for—

"(I) the internal affairs of the health systems agency, including matters relating to the staff of the agency and the agency's budget, except that the governing body for health planning of an agency which is a public regional planning body or unit of general local

government shall not be responsible for the establishment of personnel rules and practices for the staff of the agency or for the agency's budget unless authorized by the planning body or unit of government, and

"(II) procedures and criteria developed and published pursuant to section 1532 and applicable to its functions under subsections (e), (f), (g), and (h) of section 1513;".

(b) Section 1512(b)(3)(A) is amended (1) by striking out "have a governing body for health planning, which is established in accordance with subparagraph (C)," and inserting in lieu thereof "appoint a governing body for health planning in accordance with subparagraph (C)", and (2) by striking out "not more than twenty-five members" and inserting in lieu thereof "not less than ten members and of not more than thirty members".

MEETINGS AND RECORDS

SEC. 212. (a) Section 1512(b)(3)(B)(viii) is amended (1) by striking out "business meetings" and inserting in lieu thereof "business meetings (other than those parts of meetings which involve matters respecting personnel of the agency)", and (2) by striking out "records and data" and inserting in lieu thereof "records and data (other

than records and data on the personnel of the health systems agency)".

(b) Section 1512(b)(6) is amended by redesignating subparagraphs (A), (B), and (C) as subparagraphs (B), (C), and (D) and by adding before subparagraph (B) (as so redesignated) the following:

"(A) provide that any executive committee of the agency and any entity appointed by the governing body or executive committee of the agency shall (i) conduct its business meetings (other than those parts of meetings which involve matters respecting personnel of the agency) in public, (ii) give adequate notice of its meetings to those persons who have requested such notice, and (iii) make its records and data (other than records and data on personnel) available, upon request, to the public;".

(c) Section 1522(b)(6) is amended (1) by striking out "business meetings" and inserting in lieu thereof "business meetings (other than those parts of meetings involving matters respecting personnel of the agency)", and (2) by striking out "records and data" and inserting in lieu thereof "records and data (other than records and data on the personnel of the State Agency)".

(d) Section 1524(b)(3) is amended by striking out

"business meetings" and inserting in lieu thereof "business meetings (other than those parts of meetings involving personnel matters)".

SUPPORT AND REIMBURSEMENT FOR MEMBERS OF GOVERNING BODIES

SEC. 213. (a) Section 1512(b)(3) is amended by adding after subparagraph (D) (added by section 210 of this Act) the following new subparagraph:

"(E) SUPPORT.—Each health systems agency shall have an identifiable program of providing assistance to the members of its governing body, executive committee (if any), and any entity appointed by the governing body or executive committee in making decisions for the agency, and shall include in such program means to determine the support needs of the members and to provide for meeting needs (including the provision of training and continuing education).".

(b) Section 1512(b)(3)(B)(vi) is amended by striking out "reimburse" and by inserting in lieu thereof "reimburse (or when appropriate make advances to)".

CONFLICTS OF INTEREST

SEC. 214. Section 1512(b)(3) is amended by adding after subparagraph (E) (added by section 213 of this Act) the following new subparagraph:

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"(F) CONFLICTS OF INTEREST.—No member of a governing body, executive committee, or any entity appointed by a governing body or executive committee may vote on any matter before the governing body, executive committee, or any such entity respecting any individual or entity with which such member has any substantial ownership, employment, fiduciary, contractual, creditor, or consultative relationship. A governing body, executive committee, and any entity appointed by a governing body or executive committee shall require each of its members which has or has had such a relationship with an individual or entity involved in a matter before the governing body, committee, or entity to make a written disclosure of such relationship before any action is taken by the body, committee, or entity with respect to such matter.".

STAFF EXPERTISE

SEC. 215. The first sentence of section 1512(b)(2)(A) is amended (1) by striking out "and" after "health planning,", and (2) by inserting before the period a comma and the following: "(v) financial and economic analysis, and (vi) prevention of disease and other public health matters".

HEALTH PLAN REQUIREMENTS

SEC. 216. (a) Section 1524(c)(1) is amended by striking out "Review" and inserting in lieu thereof "Establish a uniform format for HSP's and review".

(b) Section 1513(b)(2) is amended by striking out "establish" in the first sentence and inserting in lieu thereof "establish (in accordance with the format prescribed pursuant to section 1524(c)(1))".

(c)(1)(A) Section 1523(a)(1) is amended by inserting "(A)" after "(1)" and by inserting before the period a comma and the following: "and (B) determine, after consultation with the Statewide Health Coordinating Council, the health needs of the State which are statewide".

(B) Section 1523(a)(2) is amended by striking out "statewide health needs" and inserting in lieu thereof "statewide health needs determined under paragraph (1)(B)".

(2) Section 1513(b)(2) is amended (A) by striking out "and" after "resources of the area;", and (B) by inserting before the period at the end of the first sentence a semicolon and the following: "and (D) which are responsive to statewide health needs as determined by the State health planning and development agency".

(3) Section 1524(c)(2) is amended by inserting "as determined by the State Agency of the State" after "statewide health needs" each place it occurs.

(d) Section 1513(b)(2) is amended by inserting after

the first sentence the following: "The HSP shall also include a statement of changes (through increases or reductions, or both) in personnel, facilities, and other resources which the agency determines are required to meet the goals set forth in the preceding sentence.".

(e) Section 1513(b)(3) is amended by adding at the end the following: "The AIP shall include a statement of the personnel, facilities, and other resources which the agency determines are required to meet the objectives described pursuant to the first sentence. Before establishing an AIP, the agency shall conduct a public hearing on the proposed AIP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed AIP, the time and place of the hearing, the place at which interested persons may review the AIP in advance of the hearing, and the place and period during which to submit written comments to the agency on the AIP.".

(f) Section 1513(b)(4) is repealed.

CRITERIA AND PROCEDURES FOR REVIEWS

SEC. 217. (a)(1) The first sentence of section 1532(a) is amended (A) by striking out "; and in performing" and inserting in lieu thereof "; in performing", and

(B) by inserting before the period a semicolon and the following: "and in performing its review functions a Statewide Health Coordinating Council shall (except to the extent approved by the Secretary) follow procedures and apply criteria developed and published by the Council in accordance with regulations of the Secretary".

(2) The second sentence of such section is amended by striking out "and State Agencies" and inserting in lieu ", State Agencies, and Statewide Health Coordinating Councils".

(b) (1) Subsections (b) and (c) of section 1532 are each amended—

(A) by striking out "agency and State Agency" each place it occurs and inserting in lieu thereof "agency, State Agency, and Statewide Health Coordinating Council", and

(B) by striking out "agency or State Agency" each place it occurs and inserting in lieu thereof "agency, State Agency, or Statewide Health Coordinating Council".

(2) Subsection (b) (4) of such section is amended by striking out "agency or a State Agency"and inserting in lieu thereof "agency, State Agency, or Statewide Health Coordinating Council".

(c) Section 1532 (a) is amended by adding at the end

the following: "Health systems agencies and the State Agency within each State shall cooperate in the development of procedures and criteria under this subsection to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews.".

CERTIFICATE OF NEED PROGRAMS

SEC. 218. (a) Part C of title XV is amended by adding at the end the following:

"CERTIFICATE OF NEED PROGRAM

"SEC. 1527. (a) The certificate of need program required by section 1523(a)(4)(B) shall provide for the following:

"(1) Review and determination of need under such program of—

"(A) major medical equipment, health care facilities, institutional health services, and home health services, and

"(B) capital expenditures,

shall be made before the time such equipment or facilities are acquired, such services or facilities are offered or developed, substantial expenditures are undertaken in preparation for such offering or development, or capital expenditures are obligated.

"(2) The acquisition, offering, and development of only such equipment, facilities, and services as may

be found by the State Agency to be needed; and the obligation of only those capital expenditures found to be needed by the State Agency.

"(3) After a certificate of need is issued an annual review shall be conducted of the progress being made in making the equipment, facility, or service for which the certificate was issued available for use, and if it is determined that adequate progress is not being made, the certificate shall be withdrawn but only after consideration of any recommendation made by the health systems agency with jurisdiction over the area to be served by such equipment, facility, or service.

"(4) In issuing a certificate of need, the State shall specify in the certificate the maximum amount of capital expenditures which may be obligated under such certificate.

"(5) The program shall provide that each decision of the State Agency not to issue a certificate of need shall, upon request of the person who applied for such certificate, be reviewed under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies.

"(6) The program shall provide that each decision of the State Agency to issue a certificate of need shall be

consistent with the State health plan in effect for such State under section 1524(c).

"(b) In granting certificates of need under such a program a State Agency shall take into account recommendations made by health systems agencies within the State under section 1513(f).".

(b)(1) Section 1523(a)(4)(B) is amended by striking out "new institutional health services proposed to be offered or developed within the State" and inserting in lieu thereof "the obligation of capital expenditures within the State and the offering and development within the State of institutional health services, home health services, health care facilities, and major medical equipment".

(2) The second sentence of section 1523(a)(4) is repealed.

(3)(A) Section 1531 is amended (i) by striking out "For purposes of this title" and inserting in lieu thereof "Except as otherwise provided, for purposes of this title", and (ii) by adding after paragraph (5) the following new paragraphs:

"(6) For purposes of sections 1523 and 1527, the term 'capital expenditure' means an expenditure—

"(A) made by or on behalf of a health care facility; and

"(B) (i) which (I) under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or (II) is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and

"(ii) which (I) exceeds $150,000, (II) changes the bed capacity of the facility with respect to which the expenditure is made, or (III) substantially changes the services of such facility.

Such term does not include an expenditure to obtain (either by purchase or under lease or comparable arrangement) an existing health care facility the services or bed capacity of which is not changed in being so obtained. For purposes of subparagraph (B) (ii) (I), the cost of any studies, surveys, designs, plans, working drawings, specification, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure described in subparagraph (B) (i) is made shall be included in determining if such expenditure exceeds $150,000. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under section 1527 shall be considered capital expenditures for purposes of sections 1523 and 1527.

"(7) For purposes of sections 1523 and 1527, the term 'major medical equipment' means medical equipment which is used for the provision of medical and other health services and which costs in excess of $150,000.".

(B) Section 1531(5) is amended by striking out "and health maintenance organizations (as such facilities and organizations" and inserting in lieu thereof "(as such facilities".

(4) Section 1532(b)(2) is amended (A) by striking out "ninety days" and inserting in lieu thereof "one year".

(5)(A) Section 1522(b)(13)(A) is amended by striking out ", by an agency of the State (other than the State health planning and development agency) designated by the Governor".

(B) Section 1522(b)(13)(B) is amended by inserting "under subparagraph (A)" after "the reviewing agency".

(6) Section 1532(c) is amended by adding at the end the following:

"(10) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed.".

(c) Within 180 days of the date of the enactment of this Act, the Secretary of Health, Education, and Welfare

shall promulgate such regulations as may be necessary to enable the States to establish certificate of need programs which meet the requirements of section 1527 of the Public Health Service Act.

APPROPRIATENESS REVIEW

SEC. 219. (a) (1) Section 1513 (g) (1) is amended by striking out "all institutional health services offered in the health service area of the agency" and inserting in lieu thereof "at least those institutional and home health services which are offered in the health service area of the agency and which have been designated by the Secretary by regulation for appropriateness review under this paragraph".

(2) Section 1523 (a) (6) is amended by striking out "all institutional health services being offered in the State" and inserting in lieu thereof "all institutional and home health services which are offered in the State and which have been designated by the Secretary for appropriateness review under this paragraph".

(b) Section 1523 (a) is amended by adding after and below paragraph (6) the following: "Within four years from the date of the enactment of the Health Planning Amendments of 1978, each State which has a State Agency designated under section 1521 (b) (3) shall have in effect a program which provides that institutional and home health services found to be inappropriate under a review conducted under paragraph (6) may not be provided in such State.".

REVIEW AND APPROVAL OF PROPOSED USES OF FEDERAL FUNDS

SEC. 220. (a) Section 1524(c)(6) is amended—

(1) by inserting "(A)" after "disapprove",

(2) by striking out "or the Comprehensive" and inserting in lieu thereof "the Drug Abuse Office and Treatment Act, or the Comprehensive", and

(3) by inserting before the period a comma and the following: "and (B) any application (and any revision of an application) submitted to the Secretary by a State for a grant or contract under any provision of law referred to in clause (A) for projects in more than one health service area of the State".

(b)(1) Section 1513(e)(1)(A)(i) is amended—

(A) by striking out "sections 409 and 410 of", and

(B) by inserting after "health resources" the following: "by or through any entity other than the government of a State unless such resources are solely within the health service area of such agency".

(2) Section 1513(e)(1)(B) is amended by striking out "under titles IV, VII, or VIII of this Act" and inserting in lieu thereof "for research or training".

(3) Section 1513(e)(2) is amended—

(A) by striking out "such paragraph" in the first

sentence and inserting in lieu thereof "paragraph (1) (A) (i)", and

(B) by striking out "If" in the second sentence and inserting in lieu thereof "If under paragraph (1) (A) (i)".

(4) Section 1513(e) is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

"(3) The Governor of a State shall allow health systems agencies sixty days to make the review required by paragraph (1) (A) (ii). If under such paragraph an agency disapproves a proposed use in its health service area of Federal funds described in paragraph (1) (A) (i), the Governor may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Governor shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Governor its comments on the decision. The Governor, after taking into consideration such State Agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Governor to make funds available shall be submitted

to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.".

COORDINATION OF HEALTH PLANNING WITH RATE REVIEW

SEC. 221. (a) Section 1513(d) is amended by inserting after the first sentence the following: "Each health systems agency shall also coordinate its activities with any entity of the State in which the agency is located which reviews the rates and budgets of health care facilities located in the health systems agency's health service area.".

(b) Section 1522(b)(7)(A) is amended by inserting before the comma at the end the following: "and for the coordination by the State Agency in the conduct of its activities with any entity of the State which reviews the rates and budgets of health care facilities in the State".

COORDINATION WITHIN STANDARD METROPOLITAN STATISTICAL AREAS

SEC. 222. Subsection (d) of section 1513 is amended (1) by inserting "(1)" after "(d)", (2) by redesignating paragraphs (1), (2), (3), and (4) as subparagraphs (A), (B), (C), and (D), respectively, and (3) by adding at the end the following:

"(2) Each health systems agency which has all or part of its health systems area within a part of a standard metropolitan statistical area (as determined by the Office of Man-

agement and Budget) shall coordinate its activities with the activities of any other health systems agency which has any part of its health systems area within such standard metropolitan statistical area. Such coordination shall be carried out in accordance with a plan approved by the Secretary which shall at least provide that each health systems agency designated for a health service area within any part of a single standard metropolitan statistical area shall review (A) each HSP and AIP for each such health service area, (B) the criteria used in accordance with section 1532 for reviews affecting any such area, and (C) each decision under certificate of need programs which affect any such area.".

STATEWIDE HEALTH COORDINATING COUNCIL COMPOSITION

SEC. 223. (a) (1) Section 1524(b) (1) (A) is amended (1) by striking out clause (ii) and by redesignating clause (iii) as clause (ii), and (2) by amending the first sentence of clause (ii) (as so redesignated) to read as follows: "The number of representatives on the SHCC to which a health systems agency is entitled shall be a number which is based on the relationship of the population of the health service area in the State of such agency to the population of the State, except that each agency shall be entitled to at least two representatives on the SHCC.".

(2) Section 1524(b) (1) (A) is amended (A) by striking out "at least five", and (B) by adding at the end

"Each agency shall submit a number of nominees to the Governor which is at least twice the number of representatives on the SHCC to which the agency is entitled.".

(b) Section 1524 (b) (2) is amended to read as follows:

"(2) The Governor shall select the chairman of the SHCC from its members.".

AUTHORIZATIONS

SEC. 224. (a) Section 1516 (d) (1) (as amended by sections 101 and 206) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $150,000,000 for the fiscal year ending September 30, 1980, $160,000,000 for the fiscal year ending September 30, 1981, $170,000,000 for the fiscal year ending September 30, 1982".

(b) Section 1525 (c) (as amended by section 101) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $35,000,000 for the fiscal year ending September 30, 1980, $37,000,000 for the fiscal year ending September 30, 1981, $39,000,000 for the fiscal year ending September 30, 1982".

(c) Section 1526 (e) (as amended by section 101) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $6,000,000 for the fiscal year ending September 30, 1980, $7,000,000 for the fiscal year ending September 30, 1981, $8,000,000 for the fiscal year ending September 30, 1982".

(d) Section 1534(d) (as amended by section 101) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $10,000,000 for the fiscal year ending September 30, 1980, $11,000,000 for the fiscal year ending September 30, 1981, $12,000,000 for the fiscal year ending September 30, 1982".

(e) Section 1640(d) (as amended by section 101) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $120,000,000 for the fiscal year ending September 30, 1980, $150,000,000 for the fiscal year ending September 30, 1981, $150,000,000 for the fiscal year ending September 30, 1982".

EFFECTIVE DATE

SEC. 225. The amendments made by this title (other than section 224) shall take effect one year after the date of

the enactment of this Act, except that on and after the date of the enactment of this Act—

(1) a health systems agency and a State health planning and development agency may make the organizational and related changes required by the amendments to sections 1512, 1522, and 1523 of the Public Health Service Act, and

(2) such agencies, State health planning and development agencies, and Statewide Health Coordinating Councils may act in accordance with the changes in their functions made by the amendments to sections 1513, 1522, 1523, 1524, 1527, and 1532 of the Public Health Service Act.

TITLE III—REVISION OF AUTHORITY FOR HEALTH RESOURCES DEVELOPMENT

REVISION AND EXTENSION OF ASSISTANCE

SEC. 301. (a) Part B of title XVI is repealed.

(b) Subsections (a) and (b) of section 1620 are amended to read as follows:

"(a) (1) The Secretary, during the period ending September 30, 1982, may, in accordance with this part, make loans from the fund established under section 1622 (d) to any public or nonprofit private entity for projects for—

"(A) modernization of medical facilities,

"(B) construction of new outpatient facilities,

"(C) construction of new inpatient medical facilities in (i) areas which have experienced (as determined under regulations of the Secretary) recent rapid population growth, or (ii) areas where merger or closure of medical facilities has resulted in a reduction in the number of hospital beds available in such areas, and

"(D) conversion of existing medical facilities for the provision of new health services.

"(2)(A) The Secretary, during the period ending September 30, 1982, may, in accordance with this part, guarantee to—

"(i) non-Federal lenders for their loans to nonprofit private entities for medical facilities projects described in paragraph (1), and

"(ii) the Federal Financing Bank for its loans to nonprofit private entities for such projects,

payment of principal and interest on such loans.

"(B) In the case of a guarantee of any loan to a nonprofit private entity under subparagraph (A)(i), the Secretary shall pay, to the holder of such loan and for and on behalf of the project for which the loan was made, amounts sufficient to reduce by 3 per centum per annum the net effective interest rate otherwise payable on such loan. Each holder of such a loan which is guaranteed under such subparagraph shall have a contractual right to receive from

the United States interest payments required by the preceding sentence.

"(b) The principal amount of a loan directly made or guaranteed under subsection (a) for a medical facilities project, when added to any other assistance provided such project under part B, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under part B, may cover up to 100 per centum of such costs.".

(c) Section 1625 is amended to read as follows:

"PROJECT GRANTS

"SEC. 1625. (a) (1) The Secretary may make grants for construction or modernization projects designed to (A) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (B) avoid noncompliance with State or voluntary licensure or accreditation standards. A grant under this paragraph may only be made to a State or political subdivision of a State, including any city, town, county, borough, hospital district authority, or public or quasi-public corporation, for a project described in the preceding sentence for any medical facility owned or operated by it.

"(2) The amount of any grant under paragraph (1) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

"(3) There are authorized to be appropriated for grants under paragraph (1) $100,000,000 for the fiscal year ending September 30, 1980, $100,000,000 for the fiscal year ending September 30, 1981, and $100,000,000 for the fiscal year ending September 30, 1982.

"(b) (1) The Secretary may make grants to public and nonprofit entities for projects for (A) construction of outpatient medical facilities to provide services for medically underserved populations, and (B) conversion of existing facilities into outpatient medical facilities to provide such services.

"(2) The amount of any grant under paragraph (1) may not exceed 80 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

"(3) There are authorized to be appropriated for grants under paragraph (1) $30,000,000 for the fiscal

year ending September 30, 1980, $40,000,000 for the fiscal year ending September 30, 1981, and $40,000,000 for the fiscal year ending September 30, 1982.".

CONFORMING AMENDMENTS

SEC. 302. (a) Part A is repealed and parts C, D, E, and F of title XVI are redesignated as parts A, B, C, and D, respectively.

(b) Part C (as so redesignated) is amended by striking out section 1630, by redesignating sections 1631 through 1635 as sections 1622 through 1626, respectively, and by inserting before section 1622 (as so redesignated) the following:

"GENERAL REGULATIONS

"SEC. 1620. The Secretary shall by regulation—

"(1) prescribe the manner in which he shall determine the priority among projects for which assistance is available under part A or B, based on the relative need of different areas for such projects and giving special consideration—

"(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

"(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

"(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

"(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid noncompliance with State or voluntary licensure or accreditation standards, and

"(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

"(2) prescribe for medical facilities projects assisted under part A or B general standards of construction, modernization, and equipment, which standards may vary on the basis of the class of facilities and their location; and

"(3) prescribe the general manner in which each entity which receives financial assistance under part A or B or has received financial assistance under part A or B or title VI shall be required to comply with the

assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (3) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

"APPLICATIONS

"SEC. 1621. (a) No loan, loan guarantee, or grant may be made under part A or B for a medical facilities project unless an application for such project has been submitted to and approved by the Secretary. If two or more entities join in a project, an application for such project may be filed by any of such entities or by all of them.

"(b) (1) An application for a medical facilities project shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall, except as provided in paragraph (2), set forth—

"(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State Agency of a continued need

for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

"(B) in the case of an application for a grant, assurances satisfactory to the Secretary that (i) the applicant making the application would not be able to complete the project for which the application is submitted without the grant applied for, and (ii) in the case of a project to construct a new medical facility, it would be inappropriate to convert an existing medical facility to provide the services to be provided through the new medical facility;

"(C) a description of the site of such project;

"(D) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1620(2);

"(E) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

"(F) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the require-

ments of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

"(G) the type of assistance being sought under part A or B for the project;

"(H) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

"(I) in the case of a project for the construction or modernization of an outpatient facility, reasonable assurance that the services of a general hospital will be available to patients at such facility who are in need of hospital care; and

"(J) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

"(2) (A) The Secretary may waive—

"(i) the requirements of subparagraph (D) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1620 (2), and

"(ii) the requirement of subparagraph (E) of paragraph (1) respecting title to a project site,

in the case of an application for a project described in subparagraph (B) of this paragraph.

"(B) A project referred to in subparagraph (A) is a project—

"(i) for the modernization of an outpatient medical facility which will provide general purpose health serv-

ices, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1633 or as designated by a health systems agency, and

"(ii) for which the applicant seeks a loan under part A the principal amount of which does not exceed $20,000.".

TECHNICAL AMENDMENTS

SEC. 303. (a) Part A (as so redesignated) is amended—

(1) by striking out section 1621 and by redesignating sections 1620 and 1622 as sections 1601 and 1602, respectively,

(2) by striking out "section 1622(d)" in subsection (a)(1) of section 1601 (as so redesignated) and inserting in lieu thereof "section 1602(d)", and

(3) by striking out "section 1620(b)(2)" each place it occurs in subsection (d) of section 1602 (as so redesignated) and inserting in lieu thereof "section 1601(a)(2)(B)".

(b) Section 1625 of part B (as so redesignated) is redesignated as section 1610.

(c) Subsection (a)(1) of section 1622 (as so redesignated) is amended by striking out "section 1604" and inserting in lieu thereof "section 1621".

(d) Section 1623 (as so redesignated) is amended by striking out "STATE" in the heading for such section.

(e) Section 1624 (as so redesignated) is amended by striking out paragraphs (1) and (2) and by redesignating paragraphs (3) through (16) as paragraphs (1) through (14), respectively.

(f) Section 1626 (as so redesignated) is amended by striking out "section 1604" and inserting in lieu thereof "section 1621".

EFFECTIVE DATE

SEC. 304. The amendments made by this title shall take effect October 1, 1979.

Mr. Rogers. We are pleased to have as our first witness today for the Department of Health, Education, and Welfare the Honorable Hale Champion, who is the Under Secretary of HEW.

Mr. Secretary, we welcome you to the committee and your colleagues, Mr. Foley, Ms. Davis and Ms. Hanft. We will be pleased to receive your statement and it will be made a part of the record in full.

We will be pleased to have your statement at this time.

STATEMENT OF HON. HALE CHAMPION, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY HENRY A. FOLEY, M.D., ADMINISTRATOR OF HEALTH RESOURCES ADMINISTRATION; KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (HEALTH); AND RUTH S. HANFT, DEPUTY ASSISTANT SECRETARY FOR HEALTH, RESEARCH AND STATISTICS

Mr. Champion. Thank you, Mr. Chairman.

I am pleased to be here today to discuss proposals to revise and extend the health planning authority first enacted in the National Health Planning and Resources Development Act of 1974.

I am also pleased to be the first HEW witness to testify this session as your subcommittee begins work on its formidable agenda. The work you will do this year holds promise for major improvements in the quality and efficiency of our Nation's health care delivery system.

I think it is appropriate that you are commencing your legislative hearings this session with the Health Planning and Resources Development Act.

Comprehensive planning at local, regional and national levels is no longer a luxury in America. It is a necessity.

It is a necessity if we are ever to implement a comprehensive, universal system for the national health. It is a necessity if we are ever to provide sufficient health care resources in areas which are underserved, while curbing unnecessary and expensive duplication in areas which are not.

It is a necessity if we are ever to fashion a flexible system responsive to all the health care needs of individuals—one which recognizes the importance of research and education to teach people how to stay healthy, in addition to providing appropriate, high quality services for them when they cannot.

In short, good planning is essential if we are ever to overcome defects and inefficiencies wrought by decades of haphazard growth, fragmentation, maldistribution, and perverse economic incentives in our national health care system.

In 1946, Congress made its first major effort to correct some of those defects and deficiencies, when it passed the Hospital Survey and Construction Act—better known as Hill-Burton.

While the primary purpose of Hill-Burton was to fund construction of new hospitals in medically underserved areas, the act also required States to survey their own health needs and develop State plans for the construction of facilities.

Hill-Burton was extremely successful as a construction program. However, its planning requirements were largely targeted on the needs of underserved areas. Moreover, some of its basic planning assumptions have since proved to be mistaken or outdated.

During the 1960's, Congress attempted to remedy that deficiency by enacting a number of planning amendments to the basic Hill-Burton Act and other health authorities. In particular, programs like the comprehensive health planning program (CHP) sought to create a structure to develop area-wide health plans and to afford local review and comment on Federal grantmaking activities. However, the outcome of these efforts was too often vague, untargeted, and ineffective. Moreover, the CHP program was hamstrung by the statutory requirement that it plan, "Without interfering with existing patterns of private professional practice of medicine, dentistry, and related healing arts."

In 1974, Congress finally scrapped the earlier, tentative planning efforts, in favor of a completely new system for health planning: The National Health Planning and Resources Development Act, which enacted the provisions before us today for review. And while that system has proved to be complex and difficult to start up, it gives every indication of some day becoming the program its visionary drafters—including you, Mr. Chairman—expected it to be: A comprehensive, nationwide planning effort for "the achievement of equal access to quality health care at reasonable cost."

For that reason, while we are submitting a number of amendments for improving the operation of the 1974 law, we agree with you, and with your colleagues in the Senate, that the basic structure of the planning act is sound, and that we should concentrate our efforts on assisting that structure to become fully operational in the months and years ahead.

The balance of my testimony this morning, Mr. Chairman, will be devoted to a brief progress report on current implementation of the act; a description of the few problems and issues we believe you should address in extending this authority; and a discussion of several of the more important amendments being proposed by the Department, and in your bill, to address those problems and issues.

CURRENT HEALTH PLANNING PROGRAM OPERATIONS

At this time, all 205 health systems agencies, with staff totaling 3,200, have been designated and funded. Although only nine HSA's have been fully designated, we anticipate that by next September 30, 175 HSA's will be fully designated. Over 8,000 people serve on the 205 HSA governing bodies.

Consumer and provider representation on these governing bodies is balanced—53 percent consumer and 47 percent providers. However, I should note that such a balance can sometimes be more theoretical than real, and we are concerned about the effects on the health planning process in such cases.

Additionally, nearly 500 advisory subarea councils with 13,000 members have been organized by many HSA's. At the State level, all 56 State health planning and development agencies have been designated. Forty-eight States have established their statewide

health coordinating councils, which are to work with the State health planning and development agencies. Some 1,700 individuals represent a mix of State and local representations.

Now that initial organizational and structural efforts are substantially behind them, most HSA's are giving highest priority to the development of their long range health systems plans and short-range annual implementation plans—in other words, the actual process of health planning has begun. Within 6 months, we anticipate that over 150 HSA's will have established their health systems plans. The development of these plans by HSA's, and the subsequent development of the State Health and Medical Facilities Plans by State agencies, is a critical step in implementation of the planning law. These plans will provide the supporting basis for HSA recommendation and State action on certificate of need and the section 1122 program, as well as other legislatively authorized activities. I have appended to my statement a more extensive status report on administration of the certificate of need and section 1122 programs.

While there has been much success in establishing the structure and beginning the health planning process at the local and State levels, I must candidly admit that the Department has been remiss in issuing regulations. After arriving at HEW last January, Secretary Califano and I discovered that only two sets of final implementing regulations for this program had been issued.

While reasons for this slow pace were offered—inadequate staff resources, complex policy issues, the need to develop supporting data, the requirements for substantial public involvement and comment, and a time-consuming issuance process—we found the lack of progress inexcusable. We are now moving as rapidly as possible to correct these problems. The establishment of national guidelines, for example, together with clear instructions on their use by State and local planners, will help HSA's plan with the greater specificity they need if their plans are to be meaningful. We expect final publication of the guidelines in early March, as soon as possible after the close of the 30-day comment period now in effect.

I would like to make a brief comment about the national health planning guidelines at this point. As we look back on the experiences of the last few months, I think we can see that HEW made three basic mistakes or misjudgments:

First, we hurried the initial guidelines too quickly into the Federal Register, because of our serious concerns about the failure of the previous administration to provide health planning leadership. In doing so and trying to get these guidelines out where people could begin to make judgments, we failed adequately to explain the process for the guidelines. Even though we used extensive previous studies and consultations in preparing them, we did not make clear what evidence had led to the conclusions drawn.

Second, in issuing the guidelines so hastily, we neglected to include in our explanatory material enough underlying description and clarification of the way this law works. The result, as you well know, was considerable misunderstanding about the powers of the HSA's

and the potential effects of the guidelines. Some persons even came to believe that HSA's had the actual power to close hospitals.

Third, we did not sapell out the discretion that HSA's should have in applying the guidelines to special local circumstances. As a result of these misjudgments, the notice of proposed rulemaking issued in September drew considerable public comment and required extensive revision. We have now listened to those comments and made the appropriate revisions. We trust the results will be satisfactory to members of this subcommittee who have been properly concerned about the effects of these mistakes on the planning law.

In addition to the national guidelines, and in keeping with our commitment to speed up the process, we have totally revised the schedule for issuing future regulations. The second issuance, including goals related to health status and health promotion, will be published for comment in the Federal Register next month. Standards related to these goals will be proposed in the spring. We also expect to have most other notices of proposed rulemaking published within the next 2 months. I have appended to my statement a more detailed report on the status of our regulation writing process.

I might add that the recent appointment of Henry Foley, who sits to my left, as Administrator of the Health Resources Administration will give the Bureau of Health Planning and Resources Development some much-needed leadership. His experience as a State administrator in Colorado has been invaluable in bringing local perspectives to the process. He has also brought a strong sense of urgency and direction to the policy development and oversight process at HRA.

MAJOR ISSUES TO CONSIDER IN RENEWAL

Now that the health planing agencies are in place and the planning process has begun, we have several particular concerns which we believe should be addressed before the program becomes too set in direction and perspective. However, as we consider legislative changes in response to these concerns, we are also mindful not to upset the significant progress that has been made to date. For that reason, we have limited ourselves to considering major issues in our proposals for extending the health planning program at this time.

One. Cost containment: Health care costs, as this subcommittee well knows, are escalating at a rate of 14 percent annually, hospital costs are going up at a rate of 15 percent annually, and there are an estimated 100,000 unnecessary hospital beds nationally. In the President's 1979 budget, we see that health expenditures are up by $5.2 billion. The increase alone is larger than our entire social services budget in the current fiscal year. It is equal to half of our entire education budget. We feel that cost containment is an urgent problem which must be addressed by the health planning program at this time and we have appreciated the concern of this subcommittee with this problem.

The Department is counting on the health planning agencies to play a major role in the hospital cost containment program already approved by this subcommittee. Under title I of the hospital cost

containment program the planning agencies will have responsibilities for: designating services as inappropriate, so that, if phased out, the revenue can remain in the hospital's base budget for purposes of calculating revenue limits; determining the need or appropriateness of various changes which could justify a hospital's exception from the revenue limit; collecting and publishing hospital fiscal information; and investigating complaints about hospital changes in admissions practices which discriminate against charity patients.

Under title II the planning agencies will have fundamental responsibilities for making the $2.5 billion limit on capital expenditures work by: administering a certificate-of-need program and approving projects only up to their allocated dollar ceiling; not approving projects for inpatient beds if the area has an oversupply or the existing beds are underutilized; and conducting appropriateness reviews of institutional health services.

We see a distinct relationship between the two programs: the federally operated cost containment program will benefit from the input of local and State decisionmakers, and the health planning program will benefit from the additional responsibilities the agencies will gain under the cost containment legislation. However, we also recognize the need to strengthen the planning agencies' basic capabilities and tools, in order for them to take on these additional responsibilities.

For example, while planners can control the amount and location of expensive equipment in hospitals through certificate of need, they cannot now control its proliferation in doctors' offices. Also, they have no mechanisms, beyond moral suasion, to promote the closure of excess services. We hope our legislative proposals will help remedy those problems.

Two. Health planning and the States: The Health Planning Act originally intended strong State and local participation in the planning process. We now see a need for an even stronger role for the States.

In recent years States have been increasingly interested in both the health services they provide and the health services they purchase, primarily because health care costs are having a critical impact on State budgets. The States are recognizing increasingly the need for a better planned and controlled health system, and we are seeing the need for stronger State support of the planning and regulatory efforts of the HSA's and State agencies. In addition, the Hospital Cost Containment Act places important decisionmaking powers at the State level. For that reason, we think it is important that the Governor both approve and support the state health plan, which will be the basis for his or her regulatory decisions. Our legislative proposal will include measures to expand the State's and Governor's roles.

Three. Health planning and local government: Local government and local officials represent a valuable resource for the health planning program, which can influence community support, and affect the implementation of plans. Currently, 25 of the Nation's 205 HSA's are public agencies. In addition, publicly elected officials or repre-

sentatives of local government constitute 15 percent of the 8,000 plus HSA governing board members. We feel that a greater involvement of public officials at the local level will promote greater leadership for the unorganized members of the community, more visibility for the planning process and better understanding and acceptance of plan implementation.

Four. Federal Administration: Finally, in our efforts to implement the original legislation, we have run into several problems of a technical or administrative nature at the Federal level. Local HSA's, State agencies, and central and regional office personnel have advised us of some of these problems, and we have discussed their solutions. For example, we feel a need for flexibility in redesignating health service areas. We believe such areas should relate as closely as possible to other relevant health planning or service areas, such as PSRO areas, or community mental health center catchment areas.

Also, we anticipate a need for being able to shift from full to conditional designation those agencies not properly assuming full designation responsibilities. In addition, we are concerned about having the administrative and funding flexibility in the future to permit State and local planning agencies to take on new responsibilities, as under the Hospital Cost Containment Act, and to enable us to take better account of the needs and capabilities of individual agencies. We are proposing several changes to deal with these and other minor administrative concerns.

PROPOSED SOLUTIONS

In the remainder of my prepared statement, I would like to describe briefly some of our legislative proposals for addressing the problems and concerns I have just identified. A complete list describing all our proposals will be submitted to you for the record [see p. 76]. In addition, we expect to submit a draft bill making these changes later this week.

One. Cost containment proposals. Title II of the administration's Hospital Cost Containment Act, which has already been considered by this subcommittee, would give health planning agencies a powerful tool for containing future inflation in hospital costs. To review that proposal briefly, a cap of $2.5 billion would be placed on new capital expenditures in order to provide State and local planning agencies the opportunity to set priorities among proposed projects. Certificates-of-need would be issued by States to only the most important projects.

As I said earlier, we appreciate the efforts of this subcommittee in reporting the Hospital Cost Containment bill to full committee and urge speedy action by the full committee.

In conjunction with the passage of the Hospital Cost Containment bill we will propose, as title III of our health planning legislation, an authorization for a grant program beginning in fiscal year 1980 to promote the closure and conversion of unneeded hospital services. While the cost containment program will permit planning agencies to limit future capital expenditures, the grant program will serve as a tool for HSA's to implement their plans with regard to existing

facilities. The program will enable them to provide financial incentives to hospitals to reduce excess capacity or convert it to fill unmet needs. Again, this is an area in which your subcommittee has taken effective action.

We anticipate that the initial Federal cost of the grant will be quickly repaid by substantial annual savings to the health system. In fact, our actuary estimates a savings of about $5 for every dollar expended.

Just last week I had a proposal from New York for closure of facilities which could have been carried out under this program which would have been enormously helpful. In fact, the return would have been much better than the $5 per dollar.

Our proposal will provide for the review, by health systems agencies and State agencies, of existing hospital facilities for their consistency with area and State plans. Those institutions designated as having excess capacity would be eligible to apply for technical assistance and grants to facilitate the elimination, either through closure, conversion, or merger of the unneeded services.

Grant funds could cover the costs of retiring related debt, providing retraining or severance pay for affected workers, and other transition/conversion expenses. The extent to which we use this new authority will depend on carefully defining the extent of the problem nationwide, and on the ability of HSA's and grantees to demonstrate that conversion and closure could not be achieved without Federal assistance.

This program will be similar in a number of ways to the grant program described in title III of your own cost containment bill. Accordingly, we look forward to working closely with your subcommittee as you draft this grant program.

To strengthen the health planning program's ability to shape all sectors of the health system, we are proposing to close a loophole in certificate-of-need. We have learned from the CAT scanner experience and we thus propose to cover all acquisition of expensive medical equipment under certificate-of-need, no matter where that equipment is to be located.

Another area in which we hope to control the rate of inflation in hospital costs is in promoting the widespread development of health maintenance organizations. In order to insure that actions of State and local planning agencies do not inhibit HMO development, we will propose that current provisions of the law subjecting the establishment of HMO's to certificate-of-need requirements be repealed.

In addition, we recently modified the first issuance of the "National Guidelines for Health Planning" to permit HSA's to adjust the national standards contained in those guidelines to take account of the special needs and circumstances of HMO's. Fnally, we will soon publish regulations to limit planning agencies' review of HMO construction projects, including inpatient facilities, to specific reasonable criteria.

Finally, we propose to require certificate-of-need decisions to be consistent with State health and medical facilities plans, which must, in turn, be consistent with national guidelines.

Two. Enhancing the role of State government: We propose to give the Governor the authority to appoint the chairperson of the State Health Coordinating Council.

In addition, to give the State health plan greater visibility and public support, we would require the Governor to formally approve that plan after it has been developed and revised by the SHPDA and the SHCC.

Three. Enhancing the role of local government. We will be submitting a proposal to expand the authority of a public regional planning body or unit of general purpose local government that also serves as an HSA. There are currently 25 such units. The regular governing board of the parent body would also be given authority over the agency's budget and would approve the health systems plan and annual implementation plan produced by the separate governing body.

To promote more widespread local participation in the planning process, we propose to require that the proportion of local elected officials or their representatives on HSA governing bodies be at least 25 percent in the future. You will recall I said it is about 15 percent now.

So that this proposal does not disrupt or interfere with the operation of current HSA boards, we will require that this proportion be achieved prospectively, as turnover occurs in existing boards. The current requirements that a majority of the board members be consumers is retained, and elected officials and their representatives may not also be counted as consumers for the purpose of meeting the requirement of consumer majority.

Finally, in order to have a more balanced local/HSA presence at the State level in the planning process, we will propose proportional representation of the HSA's on the SHCC, to replace the current requirement of an equal number of members from each HSA.

Four. Proposals to improve Federal administration of the Planning Act. First and foremost, we will be seeking to increase appropriations in fiscal year 1979 for the health planning program by more than $9 million, in order to provide better support and assistance for State and local planning agencies. In addition, we are requesting open-ended authorizations of "such sums as may be necessary" for these programs for fiscal year 1980 and 1981, so that we have added flexibility to further expand our support as the duties and responsibilities of HSA's are increased by the enactment of such programs as hospital cost containment.

In addition, we will be asking for greater flexibility in funding local HSA's, by replacing the current per capita and minimum grant funding mechanisms with greater discretion for the Secretary to set funding levels. This is considered vital if we are ever to encourage innovative advances in local planning, as well as to penalize inadequate planning bodies. However, we are aware that such a shift from a straight formula to the Secretary's discretion requires a high level of administrative capability and sophistication. We would not change the current system of allocating planning funds until we are certain that we possess such ability.

We will also propose to permit secretarial discretion to redesignate health services areas upon finding that a new area is more appropriate and that there are good reasons for change.

Another proposal will permit greater Federal discretion to split interstate HSA's at the request of either Governor, instead of requiring the concurrence of both Governors, as is currently the case, and has created at least one major deadlock as a result.

We would also permit the Secretary to return an HSA to conditional status once it has been fully designated, if it is not performing all its functions adequately.

I have mentioned the most important legislative amendments that the administration is proposing. There are several others that will be detailed in the bill and its summary.

In addition, there are other problems and issues not addressed in our legislative proposals which may deserve our attention in the weeks ahead.

We are concerned, for example, about the need for stronger linkage between the health planning program and our Community Mental Health Centers program.

Several such issues are addressed in your bill, Mr. Chairman, and in legislation introduced in the Senate. While we have not yet thoroughly analyzed all of the provisions in those bills, it is clear that many of them make useful and necessary changes in the act, and that we will be able to work together to improve and perfect our national health planning program.

You may note that we are not supporting any new authorities for health facilities construction. We understand the concerns for such programs, but do not feel that they are of sufficiently high priority to command limited Federal health funds at this time. We see a greater need for health resources development through the National Health Service Corps, ambulatory care support, and other programs.

We thank you for this opportunity to present our legislative proposals for the health planning program. We welcome the chance to continue working with you as you consider these amendments this year.

Thank you.

[Testimony resumes on p. 79.]

[Attachments to Mr. Champion's prepared statement follow:]

APPENDIX 1

STATUS REPORT:
HEALTH PLANNING REGULATIONS 1/25/78

Regulation	Due Date	Status as of 1/25/78	Explanation
1. Review & Approval	NPRM pub. 2/78	in PHS for approval	Additional time needed for internal review since this involves the programs of other PHS agencies
2. Appropriateness	NPRM pub. 2/78	in PHS for approval	
3. State Agency	Final pub. 2/78	in OS for signature	Priority given to publication of CON regulations and development of interim State Agency regulations
4. Section 1122	Final pub. 7/78	in OGC	Assigned low priority since earlier 1122 regs still in force
5. SMFP	NPRM pub. 3/78	in OGC	Draft guidelines published 8/77, followed by decision to move straight to development of NPRM rather than take intermediate step of issuing final guidelines
6. Assurances	NPRM pub. 3/78	in OGC	
7. Formula Grants Loans & Loan Guarantees	NPRM pub. 3/78	in OGC	
8. Minimum Construction Requirements	Final pub. 4/78	in BHPRD for analysis of NPRM comments	

Generally more time has been needed at every level (OS, PHS, HRA, BHPRD, and OGC) to analyze and resolve the complex legal and policy issues involved in the development of all of the health planning program regulations.

APPENDIX 2

CERTIFICATE OF NEED

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) amended the Public Health Service Act by authorizing the designation and funding of health systems agencies and State Health Planning and Development Agencies with responsibilities to perform certain review functions. Among these functions is the review of new institutional health services and facilities through State certificate of need programs.

Certificate of need programs typically are based on State statute. They represent an exercise by the State of its police powers by prohibiting the development of health facilities and services without a "certification" that the facility or service is needed. New York enacted certificate of need legislation which became effective in 1966, and since that time many States have followed its lead. Currently, thirty-six States have enacted certificate of need legislation.

The determinations of need required by these State programs resemble "certificates of public convenience and necessity" which have long been utilized in regulating public utilities. They are intended to control the costs of health care by preventing the overbuilding of health facilities and the duplication of health services, and by redirecting available health resources to the areas in which they are most needed. Although the particular provisions of these programs vary from State to State, most of them specifically discourage the construction of hospitals, nursing homes, and related health facilities

that are not in accord with State and local health plans. These certificate of need controls often apply when a proposal by one of these facilities exceeds some capital expenditure threshold, changes the bed capacity, or changes the health services offered.

The Public Health Service Act at section 1523(a)(4)(B) requires each State to administer a certificate of need program which is "satisfactory to the Secretary" of Health, Education, and Welfare. In the words of the statute, this requirement is intended to ensure "that only those services, facilities, and organizations found to be needed shall be offered or developed in the State." The statute goes on to provide minimum procedures designed to ensure that applicants for certificate of need receive timely consideration of their proposals, to guarantee a fair and open review process, and to provide an appeals mechanism for those dissatisfied with the actions taken by health planning agencies. Further, the statute details minimum considerations to be used by health planning agencies as they develop specific criteria for the review of new institutional health services and facilities.

The Department issued regulations specifying the minimum requirements for "satisfactory" State certificate of need programs on January 21, 1977 (see 42 CFR, Part 123, Subpart E).* These Federal certificate of need regulations, in setting forth the minimum requirements for State certificate of need programs, draw upon the experience of the States and the Department

*These regulations were strengthened by amendments published in the Federal Register on April 8, 1977.

in administering certificate of need and section 1122 programs, so that the weaknesses of these programs would be overcome. For example:

The Federal regulations require coverage of both hospitals and nursing homes. This has not been the case in certain State certificate of need programs. For example, the Georgia statute does not apply to hospitals; it covers only long-term care facilities.

The Federal regulations require that all non-Federal health care facilities and health maintenance organizations, regardless of ownership, be subject to certificate of need review. Such comprehensive coverage has not always been required in State programs. For example, the Kansas statute does not apply to State facilities.

The Federal regulations require States to use an enforcement mechanism that will prevent the offering or development of unneeded services and institutions before they are offered or developed. This differs from the denial of reimbursement sanction used in the section 1122 program, which does not prevent the offering or development of unneeded services and institutions.

The Federal regulations require that specific findings be made with respect to inpatient facilities before a certificate of need can be granted. This makes it especially difficult for a health planning agency to approve an unneeded inpatient facility or proposals for the provision of health services or inpatients. This is important because certificate of need and section 1122 experience indicates the strong pressure upon planning agencies to approve such projects, and because inpatient care accounts for a significant proportion of the health care dollar.

The Federal regulations require that the review process be an open and fair one, with adequate provision for public input. Certain State certificate of need programs have operated without such safeguards. For example, the Massachusetts program has been severely criticized because of the length of its review process.

The Federal regulations set forth minimum requirements; they do not preclude States from requiring more comprehensive coverage of services and facilities. In addition, the regulations permit exceptions to required procedural requirements so that States may structure their programs, within certain guidelines, to local conditions. The National Governors' Association has endorsed this approach.

> The Federal regulations require that any one of several review thresholds (new construction, significant capital expenditure, significant change in beds, new services, and predevelopment activities) should be sufficient to initiate the certificate of need review process. Many State programs (e.g., Virginia) require a significant capital expenditure either alone or in tandem with another threshold before a certificate of need review is initiated. In addition, the section 1122 program thresholds are tied to capital expenditures. Thus, new health services and significant bed changes that have a substantial effect on the institutional health care available to the community are not reviewed for need under these programs.

The Department is requiring that State Health Planning and Development Agencies administer certificate of need programs which meet the minimum Federal requirements in order to become fully designated and, thus, to participate fully in the programs authorized by Titles XV and XVI of the Public Health Service Act. The Department's Regional Offices have the primary responsibility for providing assistance to the State in the development of "satisfactory" certificate of need programs, and they have been delegated the authority to approve or disapprove the certificate of need programs of each State.

The Department is expending considerable effort in working with the States to develop certificate of need programs which comply with the Federal regulations. However, significant hurdles remain before complying certificate of need programs will have been developed:

> Developing a "satisfactory" program is not simply a matter of enacting a State certificate of need statute. The Federal statutory requirement is that a satisfactory program must be administered - this means that not only the proper legislation, but also administrative regulations, procedures manuals, and the like must be developed.

Amending an existing certificate of need statute in order to bring it into compliance with Federal regulations serves to initiate a good deal of public controversy at the State level concerning Federal-State relations, the case for health regulations, and the relationship between State-level and substate regional planning agencies.

Requiring each State to administer a satisfactory certificate of need program raises questions concerning the effectiveness of such programs. In the absence of clear-cut evidence that certificate of need programs are effective, bringing State programs into compliance with minimum Federal regulations is a difficult task.

The Federal/State relationship on the certificate of need requirement varies from State to State. In certain States there is a willingness to comply (e.g., Arkansas already has a complying program); in certain States, the legislative and executive branches have taken differing stances on certificate of need (e.g., Massachusetts); in certain States, certificate of need coverage exceeds minimum Federal requirements (e.g., Hawaii and Wisconsin).

Even if "satisfactory" programs are developed in the States the ability of certificate of need programs to promote a more rational allocation of health resources will be affected by the following issues:

Effective State certificate of need programs are dependent upon State and substate review criteria and health plans. To the extent that Federal funds do not adequately support the development of sound review criteria and health plans and to the extent that health planning agencies are required to perform project reviews without sound review criteria and health plans, the Federal goal of more rational allocation of health resources will be compromised.

The health planning law and the Federal certificate of need regulations focus on <u>institutional</u> health services in health care facilities and health maintenance organizations. Because institutional health services are with increasing frequency being offered in unregulated non-institutional settings, the application of certificate of need requirements to institutional settings alone should be reconsidered. Certain States have already extended coverage of their programs to these settings or are considering such an extension. This issue is of particular importance given the rapid development of expensive items of capital equipment which are not being located in an institutional setting

The certificate of need review function required of State Health Planning and Development Agencies is intended to promote the more efficient allocation of scarce health resources. In every State and Territory, these agencies are gearing up for certificate of need review responsibilities. If this review responsibility is assumed in gradual fashion, with the proper foundation being laid in the way of review criteria, health plans, and Federal financial support, this review should yield significant results. If this review program is structured to keep abreast of changes in the health care system (for example, the presence of institutional health services in non-institutional settings) and if it is properly integrated with other regulatory mechanisms, such as rate review, the result will be a more efficient allocation of health resources in the country.

SECTION 1122

Section 1122 of the Social Security Act was enacted as part of the Social Security Amendments of 1972. Its purpose is to reduce the incentives for health care facilities and health maintenance organizations to make capital investments in unneeded facilities and equipment and to ensure that Federal reimbursement under the Medicare, Medicaid, and Maternal and Child Health Programs (Titles V, XVIII, and XIX of the Social Security Act) is not used to support unnecessary capital expenditures. The Department of Health, Education, and Welfare has established regulations to implement the statute and policy guidelines to deal with the more complex aspects of the program.

States participate in the program on a voluntary basis: thirty-seven States currently have agreements with the Department to administer section 1122. Under these agreements, the designated planning agency for a State (the DPA) makes findings as to the conformity of proposed capital expenditures with applicable standards, criteria, and plans developed under the Public Health Service Act (and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963). If the DPA finds that a capital expenditure does not so conform, the Department is authorized to withhold the capital-related reimbursement from payments to the facility under Titles V, XVIII, and XIX of the Social Security Act.

The Federal role in administering the program, which has been largely decentralized to the Department's Regional Offices, is severely limited. State DPAs are given the decisionmaking role in the program. If a DPA makes a finding that an expenditure is in conformity with applicable plans, criteria, and standards, and if the proponent of the expenditure complied with the notification requirements of the statute and regulations, the Department has no authority to withhold reimbursement under section 1122, even if it disagrees substantively with the State's finding.

Data compiled by the Health Resources Administration reflect that in certain States, administration of the section 1122 review program - sometimes in conjunction with a State certificate of need program - has become increasingly aggressive in recent years. These data indicate that a greater amount of capital expenditure proposals are being disapproved, particularly those for new inpatient beds and new facilities.

To illustrate:

- In 1976, the Florida DPA disapproved 17.2% of the amount of capital expenditures subject to section 1122 proposed in the State, and the figures for the proceeding years are as follows:

1973	.6%
1974	8.9%
1975	10.5%

- The corresponding figures for Maryland are:

1973	0.0%
1974	4.6%
1975	4.1%
1976	21.9%

- Thirty percent of the amount of capital expenditures proposed for the purpose of constructing new health care facilities has been disapproved by the Florida DPA since the beginning of the program, while only 2% of those capital expenditures proposed for renovations was disapproved.

- Thirteen percent of the amount of capital expenditures proposed for new facilities has been disapproved by the Maryland DPA since the beginning of the program, while only 2% of those expenditures proposed for renovations was disapproved.

- Proposals to add beds to facilities were disapproved at a significantly higher rate than other proposals. For example, the disapproval rate of proposed bed additions in Missouri during the time it participated in section 1122 was 10%, while the rate of disapproval of the total amount of proposed capital expenditures was only 3%.

Yet, serious problems continue to hamper the effectiveness of the program. For example, in accordance with the Federal statute and regulations, the Department may not withhold reimbursement for a capital project - even where a DPA has submitted a finding that the proposal is not in conformity with its plans - if the DPA makes any one of a number of procedural errors in conducting its review. Thus, the Department has been committed to providing Medicare and Medicaid reimbursement for a number of unnecessary capital expenditures. For example:

- The construction of a new hospital in Louisiana took place because the DPA, misinterpreting the Federal regulations, took 93 days to make its decision that the facility was unneeded rather than the required 90 days.

- Federal reimbursement will be provided for the construction of three unneeded nursing homes in Mississippi. Under the section 1122 statute, when a proposal is disapproved by a DPA, the proponent of the expenditure must be offered the opportunity for a fair hearing. The section 1122 regulations further provide that the failure of a fair hearing officer to make a decision within the required time period is a procedural error that has the effect of reversing a DPA's disapproval action. In this instance, the fair hearing officer intentionally allowed the review period to expire. This State hearing officer was removed from future participation in the section 1122 appeals process due to these actions; the Department was, nevertheless, obliged to provide reimbursement for three nursing homes which the Mississippi DPA had found to be unneeded.

When a DPA makes a decision inconsistent with its own plans or criteria - or those of the health systems agency - the Department is powerless to reverse that decision or even to ask the DPA to reconsider its decision.

- The Ohio DPA recently reviewed a $14 million proposal for a new acute-care hospital and forwarded to the Department its finding that the proposal conformed to its standards, criteria, and plans. However, in a letter to the health systems agency (which had reviewed and recommended disapproval of the construction project), the DPA stated that its approval of this and another proposal actually conflicted with the bed-need projections in the State's Hill-Burton plan. The Department was legally required to issue a determination that reimbursement would be provided for this unnecessary facility.

The Department's recourse in this and similar cases is limited: there is nothing in the section 1122 statute which authorizes the withholding of reimbursement to a facility on grounds that a DPA violated the terms of its section 1122 agreement with the Department.

Nor does the section 1122 statute give the Department authority to prescribe standards and criteria for use by health planning agencies in reviewing proposed capital expenditures, and many of these agencies continue to rely on only general considerations outlined by the Department in 1973. When only these general considerations are used as basis for disapproval, health care facilities are in a position to challenge successfully DPA decisions.

New technology also presents a problem for planning agencies carrying out the section 1122 program.

- Applications for CT scanners poured in before health planning agencies could develop criteria for review, and these agencies were often unable to make informed decisions as to need.

- Although there is no authority to establish a moratorium on reviewing certain kinds of proposals under section 1122, at least two States -- Missouri and New Hampshire -- attempted to do so, with Missouri achieving partial success (due to the cooperation of health providers) until it terminated its participation in the section 1122 review program.

- Even where adequate criteria have been developed, section 1122 does not give planning agencies authority to review expensive medical purchases in non-institutional settings. Thus, it is not uncommon for a group of physicians to purchase a CT scanner and locate it in close proximity to a hospital, when the hospital had been or would be disapproved for the same purchase.

- The existing statutory authority to cover capital expenditures "by or on behalf of" covered health care facilties and health maintenance organizations is limited in its effect. In one case in Maine, a group of physicians purchased a CT scanner but installed it in a hospital. Even though the hospital planned to do the billing for the CAT scanning service, there was still inadequate legal support for the position that the purchase was "on behalf of" the hospital - mainly because title to the scanner and responsibility for taxes was with the medical group and not the facility. Thus, the purchase was not reviewed under the section 1122 program.

The section 1122 sanction (the withholding of reimbursement for unneeded capital expenditures) is sometimes not strong enough even when it can be applied.

- One Indiana facility was able to arrange tentative financing for a proposed expansion project despite probable DPA disapproval based on financial feasibility projections which excluded the capital related reimbursement.

- Section 1122 is also ineffective in controlling costs where little or no initial capital investment is involved, such as when beds are converted to a higher level of care.

Although increasing experience with administering both the section 1122 program and certificate of need programs in States will undoubtedly continue to improve the effectiveness of these programs in containing health care costs, this experience also points toward possible changes in the section 1122 statute.

Status of Certificate of Need
and Section 1122 Programs in the States
(as of August 31, 1977)

State	Year Certificate of Need First Enacted	Effective Date of Section 1122 Agreement
Alabama	1977	9/18/73
Alaska	1977	4/01/74
Arizona	1971	- - - -
Arkansas	1975	7/01/73
California	1969	- - - -
Colorado	1973	3/01/74
Connecticut	1969	- - - -
Delaware	----	7/01/73
Florida	1972	1/01/73
Georgia	1974	2/27/74
Hawaii	1974	~~8/16/73~~ (terminated 2/28/77)
Idaho	----	7/01/74
Illinois	1974	- - - -
Indiana	----	7/01/73
Iowa	1977	3/07/73
Kansas	1972	- - - -
Kentucky	1972	3/15/74
Louisiana	----	5/16/73
Maine	----	3/01/73
Maryland	1968	2/15/74
Massachusetts	1971	- - - -
Michigan	1972	12/14/73
Minnesota	1971	2/25/74
Mississippi	----	6/25/73
Missouri	----	~~6/16/73~~ (terminated 6/30/76)
Montana	1975	2/26/74
Nebraska	----	2/26/73
Nevada	1971	3/15/74
New Hampshire	----	4/01/73
New Jersey	1971	2/28/74
New Mexico	----	7/01/73
New York	1964	2/28/74
North Carolina	----	4/02/73
North Dakota	1971	2/28/74
Ohio	1975	6/28/74

State	Year Certificate of Need First Enacted	Effective Date of Section 1122 Agreement
Oklahoma	1971	2/27/74
Oregon	1971	3/01/74
Pennsylvania	----	3/01/73
Rhode Island	1968	- - - -
South Carolina	1971	3/15/74
South Dakota	1972	- - - -
Tennessee	1973	- - - -
Texas	1975	- - - -
Utah	----	2/26/74
Vermont	----	1/02/75
Virginia	1973	~~7/01/73~~ (terminated 6/30/76)
Washington	1971	2/01/74
West Virginia	1977	3/15/77
Wisconsin	1977	9/01/73
Wyoming	1977	2/28/74
District of Columbia	(By Regulation in the mid-1960's)	- - - -
Guam	----	5/06/74
Puerto Rico	1975	2/28/74
Trust Territory	----	- - - -
Virgin Islands	----	- - - -
Total	36 States 1 Territory plus the District of Columbia	37 States 2 Territories 3 States terminated

Division of Regulatory Activities
Bureau of Health Planning and Resource Development
HRA,PHS,DHEW
September 1977

1.2"

SUMMARY OF H.R. 11077
ADMINISTRATIVE HEALTH PLANNING AMENDMENTS

TITLE I

Section 101 would authorize appropriations for fiscal years 1979, 1980, and 1981 for health planning activities.

TITLE II

Section 201 would permit the Secretary to divide a standard metropolitan statistical area into two or more health service areas if the Governor of any State involved so requests. Currently the Governor of each State involved must so request.

Section 202 would authorize the Secretary of Health, Education, and Welfare to change the boundary of a health service area if another boundary would be more suitable. The Secretary may now change the boundary only if the existing boundary ceases to meet statutory requirements.

Section 203 would expand the authority of a public regional planning body or unit of general local government that serves as an HSA, in relation to the authority of the separate governing body for health planning. The parent body would be empowered to approve the budget of the separate governing body for health planning, the health systems plan, and the annual implementation plan. The parent body could also remove for cause members of the separate governing body for health planning.

Section 204 would exempt personnel records from the requirement that HSAs, SHPDAs, and SHCCs make their records available to the public.

Section 205 would permit individuals to serve as consumer representatives on HSAs although they had been classified as "indirect providers" during the immediately preceding year (often because they had served as members of a health institution's governing board).

Section 206 would permit certain "providers" to serve on HSAs as "provider" representatives although they do not fall into one of five currently specified classes.

Section 207 would require nonmetropolitan representation on HSAs at least equal to the proportion of nonmetropolitan residents in the health service area. Currently the representation must be equal to the proportion of those residents in the health service area.

Section 208 would require that at least one quarter of each HSA's membership consist of representatives of governmental authorities, and would apply the current provision concerned with consumer representation only to consumers who were not such representatives.

Section 209 would permit HSAs to accept contributions from health insurers.

Section 210 would permit the Secretary to return to conditional status for not more than 24 months an HSA which was experiencing difficulty in meeting all the requirements applicable to HSAs.

Section 211 would permit HSAs and SHPDAs to use funds granted in a fiscal year in the following fiscal year.

Section 212 would replace the present allocation of grants to HSAs on a formula basis with grants whose amounts would be determined by the Secretary.

Section 213 would require State certificate of need programs to determine the need for major medical equipment, whether or not located in a medical institution, but would eliminate the requirement that those programs determine the need for the establishment of health maintenance organizations.

Section 214 would require a State, before granting a certificate of need to a project, to determine that the project was consistent with the State medical facilities plan and the State health plan.

Section 215 would delete a redundant requirement for State review of new institutional health services.

Section 216 would provide for representation of HSAs on SHCCs based on the population in each HSA's area, rather than on the current basis of equal representation for each HSA.

Section 217 would direct the Governor of a State to appoint the chairman of the SHCC; currently the SHCC members choose their own chairman.

Section 218 would subject the State health plan developed by the SHCC to approval by the Governor.

Section 219 would require HSAs and SHPDAs, in reviewing the facilities, equipment, or services of health maintenance organizations, to utilize only those criteria specified by the Secretary.

Section 220 would enact technical amendments to the Public Health Service Act.

Section 221 would provide for effective dates.

TITLE III

Section 301 would permit the Secretary to make grants to public or nonprofit private hospitals that have been in operation for at least two years to assist them in discontinuing inappropriate inpatient hospital services. A hospital could not receive a grant unless the SHPDA, after consulting with the HSA, determined that the hospital was providing inappropriate services. In addition, the Secretary would have to determine that the grant would decrease the average per capita inpatient expenses of hospitals in the health service area. The Secretary could provide grant funds to assist in liquidating the outstanding debt of a hospital that was closing, providing severance pay and retraining to affected employees, converting part of a hospital from use for inpatient care to other health care uses, and meeting other costs associated with the discontinuation of the inappropriate services.

Section 302 would authorize the Secretary to provide technical assistance to hospitals eligible for grants under this title.

Section 303 would authorize appropriations of "such sums as may be necessary" for fiscal years 1980 and 1981.

[The text of bill 11077 can be found on page 1420.]

Mr. ROGERS. Thank you very much, Mr. Secretary, for a very helpful statement.

I might state this committee normally will not approve open-ended funding so it would be helpful to us if you would let us have recommended amounts for the years mentioned. That is all I wanted to mention at this time.

Dr. Carter, you may question.

Mr. CARTER. Mr. Chairman, I yield to you on anything, but that is certainly something that I meant to bring up because an open-ended authorization is a procedure which is not usually followed by this committee or by very few committees in the House.

I notice that you would retain the $2.5 billion count on expenditures, is that correct?

Mr. CHAMPION. That is correct, sir.

Mr. CARTER. Where do you envision that most of these expenditures will be made and for what purposes?

Mr. CHAMPION. I think our assumptions have not basically changed from the original recommendation and that is that we have a large requirement for modernizations, for improvements, some of which are actually money-saving, energy saving, and so on.

Mr. CARTER. Modernization in what areas particularly?

Mr. CHAMPION. You mean geographic areas?

Mr. CARTER. No, sir. In what departments of hospitals particularly.

Mr. CHAMPION. I am afraid I could not speak specifically to that.

Mr. CARTER. The outpatient departments and so on, would you not think that would be appropriate?

Mr. CHAMPION. Yes; particularly with respect to urban hospitals where emergency rooms are overrun by ambulatory care.

Mr. CARTER. Each year charitable institutions and people in this country give $4 billion to hospitals. Do you mean that you would not permit this $4 billion to be used for capital expenditures by keeping your capital limit at $2.5 billion?

Mr. CHAMPION. That, as I understand, is the basis of our proposal.

Mr. CARTER. Yes, sir. If you recall we have included that particular limit in the cost containment bill. It seems incomprehensible that we would use tax money for this purpose when we have that much in charity coming in, much more than your limit each year. I would certainly hate to dry up these charitable funds, would you not? Or would you rather let the taxpayers pay it?

Mr. CHAMPION. Well, Mr. Chairman, our problem is in limiting the capital expenditures so that operational funding is limited. We certainly would like to see the philanthropy help support operational costs. What we are trying to avoid, I think, is having capital costs drive up the amount of money the Government, taxpayers, everybody, has to pay in terms of operating costs.

Mr. CARTER. This would help to improve the very hospitals which need improvement at this time in their outpatient departments, emergency rooms, and so on. There is a great need for this, a crying need, as I understand it.

Now I notice that you would limit the capital funding for doctors' offices, too, is that correct?

Mr. CHAMPION. Yes; that is correct, with respect to the equipment.

Mr. CARTER. Yes, sir. We will have to get a certificate of need, is that correct?

Mr. CHAMPION. That is my understanding.

Mr. CARTER. Would it be very difficult for them to do it? What about the Mayo Clinic which actually has 70 percent of its patients come from outside of its HSA. Would you limit it to the population within its HSA when it serves many people from all over the world?

Mr. CHAMPION. I think that for special circumstances, the certificate-of-need system is set up to take that into consideration.

Mr. CARTER. Yes, sir; but you didn't mention that. We did mention it in our legislation on cost containment and I would hope that you would do so here. These facilities are medical resources for the entire country, and we would not preclude their preeminence and their success. We don't want to stop innovation, do we, and see to it that we have no more? We would not want to do that, would we?

Mr. CHAMPION. No, Doctor, but I do think that we need to be concerned that this is looked at realistically in terms of the national requirement.

Mr. CARTER. Yes, sir. At the same time you would put no limit whatsoever on HMO's, you would let them get anything they want including a C.A.T. scanner, is that correct?

Mr. CHAMPION. No; that is not the intention.

Mr. CARTER. Well, according to your statement, it appears that way.

Mr. CHAMPION. The intention is to specify specific criteria and limit it to that.

Mr. CARTER. According to what you say, they are completely exempted, as I understand it, sir, and if you will read it back, I believe that is correct.

Mr. CHAMPION. Dr. Carter, that is a misstatement. My statement referred to the establishment of HMO's, not to their activities.

Mr. CARTER. If I am wrong, I will be glad to admit it, but that is the way I read it.

Mr. CHAMPION. Let me read it back because I think the intention is to exempt the establishment of HMO's, because in establishing an HMO now there are requirements beyond those of fee for service organizations. What we intended to say here——

Mr. CARTER. What you intended to say.

Mr. CHAMPION. On page 18, Dr. Carter, it says, "current provisions of the law subjecting the establishment of HMO's to certificate-of-need requirements be repealed."

Mr. CARTER. Yes, sir.

Mr. CHAMPION. By that we mean the formation of the group, not their continuing activities.

Mr. CARTER. Well, even then you exempt them.

Thank you.

There is one other question. You give the Governor of the State authority to appoint the chairman of the SHCC. Actually, the health planning system was developed as it was so that people themselves would make the decisions throughout our country, particularly through the health systems agencies. To foster this we gave the

State health coordinating group final approval of the State health plan. Now you are proposing that we place all this under the Governor? Is that correct, and you would let him appoint the chairman of this group?

Mr. CHAMPION. Yes, that is the only change in the formation of that group, I think.

Mr. CARTER. Of course, I am sure you want it to be nonpolitical. Then would you want the State Senate to confirm such an appointment?

Mr. CHAMPION. I think that would be in the discretion of the State. There are different patterns in different States, Dr. Carter. I could not speak to that.

Mr. CARTER. You could not speak to that. You would not care whether it is political or not or care whether it had confirmation by the Senate? Is it usual in a position such as yours to be confirmed by the Senate of the United States, is it not?

Mr. CHAMPION. Yes, sir, that is correct.

Mr. CARTER. All right. What special expertise does the Governor have that he can overrule HSA's? According to your proposal I believe he could. After these people have fought these things out, and they have experts on their board, do you think that the Governor should be permitted to say, no, you are wrong, we are going to put a hospital over here at this place.

Mr. CHAMPION. No.

Mr. CARTER. He will have the final say on the certificate-of-need? That could be politically used. Do you think that is right?

Mr. CHAMPION. What is contemplated here, Dr. Carter, is that the Governor must approve the plans not that he would change it. The procedure would be to go back and to rework the scheme until it is acceptable to the Governor, and the prime reason for that suggestion is because the Governor does largely control the implementation of this plan, so that to have the plan out of synch with his operating agencies would make it less effective.

Mr. CARTER. Well, it was not the intention of this committee, as I understand it, to put it in the hands of the Governor. We wanted to put it in the hands of the people themselves, the different HSA's, and now you are proposing to confine it to one person. If you give him the control over a certificate-of-need, and with many of them being political animals, I think they will give the certificates-of-need wherever they want to. I think that that is unwarranted, Doctor.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman.

I would like to ask a question and I refer to the existing law, section 1501 (c) of Public Law 93–641. I would like for you, if you will, to explain to me how your department interprets the words "consult with," and I am referring to that section which says as follows:

> In issuing guidelines under subsection (a) the Secretary shall consult with and solicit recommendations and comments from the health systems agencies designated under part B, the State health planning and development agencies designated under part C, the statewide health coordinating councils estab-

lished under part C, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 1503.

Again, my question is, How does your department interpret the words "consult with"?

Mr. CHAMPION. In a number of ways. One way is through the process itself. There is a stage of the process at which anything we suggest is open to discussion and comment. We have just been through one of those periods.

Mr. SATTERFIELD. Are you talking about the 30-day period after you issue the proposed guidelines?

Mr. CHAMPION. That is correct, and that period was extended, as I said earlier in my prepared statement. We were so far behind when we released the first notice, the planning council had not yet had its first meeting. That meeting was scheduled, and we tried to do a number of things together—that is, to have the guidelines out before the public and get people's comments on them, at the same time the council members themselves had a chance to work with them.

We did compress that consultation process more than we normally would. We are consulting with everyone on all of the guidelines that are now in preparation, and we have worked the first guideline through a second NPRM now in order to make sure that everybody has had a chance to be heard and consulted before the regulations become final.

Mr. SATTERFIELD. That is, under your regular process of allowing 30 days for written comments to be considered before you issue your final guidelines.

Mr. CHAMPION. That is right, but we do believe that there is an obligation to consult before that time and we have been consulting before that time on all of the other guidelines.

Mr. SATTERFIELD. Are you familiar with the testimony of Dr. Richmond before this subcommittee with respect to the guidelines that were issued last year? In response to my question as to whether or not any of the agencies I have just mentioned had been consulted prior to the issuance of the proposed guidelines, he answered no. Are you familiar with that testimony?

Mr. CHAMPION. No, I am not.

Dr. Foley.

Dr. FOLEY. I think that hearing record, Congressman, should be corrected, in that Dr. Richmond at that point did not have the specific information at hand.

Mr. SATTERFIELD. Wait a minute. If Dr. Richmond thinks that his testimony is wrong, it is up to Dr. Richmond to correct it. Now, I am talking about what is on the record at those hearings.

Dr. FOLEY. Let me clarify for the record then that the SHCC's and the health systems agencies were in fact consulted prior to the issuance in September and I will be glad to get you that list.

Mr. SATTERFIELD. I would like to have that list because I have been in touch with some of them and I tell you right now a lot of them were not consulted.

Are you telling me that every State health planning agency and health systems agency in this country has been consulted?

Dr. FOLEY. I am saying that a good number of them had prior to the October 1976 draft in terms of the guidelines which was the basic document for the revision that came out in September.

Mr. SATTERFIELD. What is your name, sir?

Dr. FOLEY. Dr. Foley.

Mr. SATTERFIELD. Dr. what?

Dr. FOLEY. Foley.

Mr. SATTERFIELD. Dr. Foley, were you involved in that consultation?

Dr. FOLEY. No; I was not involved.

Mr. SATTERFIELD. How do you know it occurred?

Dr. FOLEY. Because I have checked with staff and I have checked with the HSA's and the SHCC's, Congressman, as you have.

Mr. SATTERFIELD. I am going to get my full list and I am going to make it a part of this record if I can get it in before these hearings are over.

[The following material was received for the record:]

STATEMENT OF REPRESENTATIVE DAVID E. SATTERFIELD, III, IN CONSULTATION REGARDING PROPOSED GUIDELINES FOR HSA'S AND SHPDA'S

On December 27, 1977, letters were sent to all of the Health Systems Agencies and State Health Planning and Development Agencies except those in Virginia, which had already been contacted. The HSAs and SHPDAs were asked to respond to questions concerning the Proposed National Health Planning Guidelines published September 23, 1977.

As of April 1, 1978, one hundred and thirty-three responses had been received. Of those responding, one hundred and twenty-two indicated they were not consulted in the issuance of the guidelines. Seven felt that they were consulted, and the response of the remaining four is unclear. In addition, a majority of the respondents took the position that the proposed guidelines were, in whole or in part, inappropriate for their state or Health Services Area.

Copies of the letters sent to the HSAs and SHPDAs and their replies are available for inspection in the Office of the Subcommittee on Health and the Environment.

Mr. SATTERFIELD. I would like to know what additional consultation has been had with these same agencies since the original proposed guidelines were issued which have led to new guidelines that are proposed. What consultations have occurred?

Dr. FOLEY. We have a list of the agencies, Congressman, again that were consulted from September through the end of December.

Mr. SATTERFIELD. You consulted with them?

Dr. FOLEY. Yes, from September through December, both the HSA's and the SHCC's. We have written comments from them.

Mr. SATTERFIELD. Under the 30-day comment period?

Dr. FOLEY. I consider consultation to have occurred during the period from September to December. This consultation has included written comments and the proposed revisions presented to the National Health Planning Council. We have solicited comments from planning agencies comments during this 30-day period that the Under Secretary has referred to, and will be considering them carefully.

[The following letter was received for the record:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
HYATTSVILLE, MARYLAND 20782

OFFICE OF THE ADMINISTRATOR

February 15, 1978

Honorable Paul G. Rogers
House of Representatives
Washington, D. C. 20515

Dear Mr. Rogers:

During the recent hearings before the Subcommittee on Health and the Environment on amendments to the Health Planning legislation, several questions were raised regarding consultation in the development of the National Guidelines for Health Planning, as required by Section 1501(c).

The consultation process in the development of the National Guidelines has been extensive. It has included, and has gone well beyond, the specific groups that are identified in Section 1501(c) - Health Systems Agencies, State health planning and development agencies, Statewide Health Coordinating Councils, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development.

On June 12, 1975, a Notice was published in the Federal Register requesting comments and suggestions on the health planning goals and resource standards called for in Section 1501. The Notice was mailed to approximately one hundred health groups representing both professional and consumer interests, soliciting their recommendations.

Arrangements were made for the development of a series of papers designed to identify and analyze issues that might be addressed in the National Guidelines. Groups of interested individuals from around the Nation were brought together through organizations such as the Center for Disease Control, The Harvard School of Public Health and The American Association of Comprehensive Health Planning to assist in the consideration of the Guidelines. Many of the products of these deliberations have been published in the three volumes of Background Papers on the National Guidelines.

An initial set of 24 planning goals, developed on the basis of the ideas and comments received as well as reviews of available literature, was distributed for review in July 1976, and approximately 200 individual comments received.

In October 1976, a more extensive draft was developed for public distribution and review. This draft included 11 potential goals and subgoals, 25 resource standards, as well as seven health planning principles. Two of the draft resource standards addressed hospital bed supply and occupancy rates.

The purpose of the October 1976 draft was to encourage and focus more widespread consideration of potential National Guidelines. The draft was sent to State and local health planning agencies, a large number of medical and other health professional associations, and interested consumer groups. In the following months, each HEW Regional Office organized a series of public meetings on the draft Guidelines; some were held in local communities, and others on a Statewide and Regional basis. A total of approximately 1,100 individual comments were received and analyzed.

The Notice of Proposed Rulemaking on the National Guidelines published September 23, 1977, included 11 proposed resource standards. Two of the standards, regarding hospital bed supply and occupancy rates, were similar to those included in the October draft. A third proposal addressed standards on End-Stage Renal Disease previously issued under the Medicare program. The other proposed standards were based on an extensive review of the literature, including standards developed by professional organizations, health planning agencies and others. These standards were usually based on a process of broad consultation involving medical specialists, local practitioners and consumers. For example, the Institute of Medicine and Inter-Society Commission on Heart Disease Resources involved experts from throughout the Nation in the development of their Reports.

The Federal Register Notice was mailed directly to all State and local health planning agencies and to over a hundred health professional and consumer groups for review. Panels of experts, including medical specialists, health administrators, health planners, and consumers, were convened in a series of Public Meetings on the National Guidelines held November 7, 8, 15, 16, and 17 to discuss their recommendations on the proposed Guidelines. In addition, members of the general public were provided an opportunity to present their views.

The National Council on Health Planning and Development considered the proposed Guidelines at their meetings in September, October, November, and December. Three full days - December 9, 10, and 21 - were devoted specifically to discussion of the proposals. At the later meeting, 11 resolutions were passed, providing comments and recommendations to the Secretary. During these meetings, an opportunity for public comment was also provided.

The comment period on the September 23 Notice was extended from November 22 to December 9, to provide additional time for interested parties to comment. Over 55,000 comments were received, and these have been carefully analyzed and considered.

The second Notice of Proposed Rulemaking on the initial National Guidelines, issued on January 20, 1978, has also been distributed widely for review and comment. To date, approximately 5,000 copies have been sent directly to all State and local health planning agencies, medical and other health professional organizations who have commented on earlier materials, members of the expert panel, and a large number of other health groups. The National Council on Health Planning and Development reviewed the proposals at its meeting on February 10, 1978.

Please let me know if you have any further questions with respect to the Department's activities in the development of the Guidelines. I appreciated the opportunity to appear before you to discuss the Health Planning Program, and look forward to working with you in the future.

Sincerely yours,

Henry A. Foley

Henry A. Foley, Ph.D.
Administrator

Mr. SATTERFIELD. I am not going to argue, but I would point out that if Congress had intended the 30-day comment period and responses as a result of the notice published in the Federal Register to constitute consultation, we would have had no reason to include section 1501(c) in the act. I believe that inclusion of section 1501 (c) is proof positive that more was intended.

I would like to ask some additional questions. On page 1 of your statement, Mr. Champion, at the bottom of the first page you say: "It is a necessity if we are ever to implement a comprehensive, universal system for the national health."

Elucidate for me just what kind of a universal system for the national health you envision.

Mr. CHAMPION. We are not ready to make a proposal. What I am speaking of here is a more general thing; that is, universal access, a system to which everyone has equal access at a reasonable cost under whatever provisions.

Mr. SATTERFIELD. Are you talking about a national health system which would be basically directed by your department?

Mr. CHAMPION. This would be true with or without such a national health system.

Mr. SATTERFIELD. What, the direction from your department?

Mr. CHAMPION. No, that we need to have comprehensive planning to implement a comprehensive universal health care delivery system whether it is governmental or otherwise.

Mr. SATTERFIELD. I am not too concerned about a comprehensive health system if it is reasonable, but I am concerned about this principle of universality. That implies a national system. Is that what you envision?

Mr. CHAMPION. It means universal access, sir.

Mr. SATTERFIELD. Universal access to what?

Mr. CHAMPION. It means that every person in this country should have access to the health care system.

Mr. SATTERFIELD. Now I gather in reading your statement, and referring specifically to page 9, that hospital cost containment is one of the prime concerns in connection with this act and the amendments you feel should be made to it. I would like to ask this question. In the event that the Hospital Cost Containment Act to which you refer and which this subcommittee has reported to the full committee is not enacted in this Congress, do you feel that the health planning act as now constituted would authorize your department to require the State health planning and development agencies to include limitations on increases in hospital revenues in their State health plans?

In other words, do you think HEW would have the capability under this act to achieve the same result as the cost containment bill intends by requiring the health system agencies to incorporate revenue limits for hospitals as part of their State health plans?

Mr. CHAMPION. No; I do not. I think there is the potential to offer guidelines for State action but there is not the authority contained in the hospital cost containment.

Mr. SATTERFIELD. I am interested in your statement because it leads to another question. Maybe this is a good time to ask it. Would you give me your definition of a guideline?

Mr. CHAMPION. A guideline, as we have interpreted it in writing these national guidelines, is a benchmark or a standard against which local and State health planning agencies can measure their efforts and against which we can measure them in terms of their effectiveness.

Mr. SATTERFIELD. Is it not a fact that the guidelines you have already issued are not guidelines in that sense but directives and that you are going to require adherence to them?

Mr. CHAMPION. The only requirement for adherence, the only remedy for failure to adhere—and there is in the present version of those guidelines adequate room for State and local planners to make all the kinds of adjustments for special circumstances—the only action the Federal Government is able to take is to change the status of the health planning agency itself, not to do anything else.

Mr. SATTERFIELD. Right. And if you change it, you eventually can put together more cooperative HSA in its place, can't you?

Mr. CHAMPION. I think use of that authority would be very limited. We would certainly hope that the planning process is effective without the need for such action, in the sense that it does provide a strong framework. But the health planning law does not do the same things that a Cost Containment Act would do.

Mr. SATTERFIELD. You also have the right to withhold funds, if necessary.

Mr. CHAMPION. That is limited.

Mr. SATTERFIELD. The point I am getting to is this: If you are talking about hospital cost containment and revenues being limited through guidelines, are you not saying that you are going to come up with a set of guidelines saying to the HSA's that these are the standard revenues, and you are going to have to put them in your health plan and, we are not going to approve the plan, and we will change your status?

Mr. CHAMPION. We do not have formal approval of those plans, Mr. Satterfield.

Mr. SATTERFIELD. You have the power not to approve them.

Mr. CHAMPION. No, we do not.

Mr. SATTERFIELD. You do not.

Mr. CHAMPION. We have, as I understand it, the ability to review them but not to approve them.

Mr. SATTERFIELD. Now you have said in your guidelines that were published last year—that every HSA would have to include them within the health systems plan within 1 year and comply with them in 4 additional years, is that not correct?

Mr. CHAMPION. No, sir. Things would go into plans under those guidelines, but we do not write those planning provisions. Those provisions are written first by the HSA's and then by the appropriate State agencies.

Mr. SATTERFIELD. You have the right to make them comply.

Mr. CHAMPION. We give them guidelines as I defined them.

Mr. SATTERFIELD. You give them requirements that must be met or they are in trouble with you.

Mr. CHAMPION. Well, I think I stand on my previous statement, sir.

Mr. SATTERFIELD. Well, you can stand on it but I am bound to say I consider the guidelines you issued to be directives. The point that I am leading to is that there are provisions and proposals that I see you making here that lead to the conclusion that you will have ready control over these plans if they do not comply.

Mr. CHAMPION. We think we have simply performed the function that was assigned to us by the act as passed in 1974.

Mr. SATTERFIELD. Well, I am glad to know that because that may give me some ideas as to how we ought to amend it.

I would like to ask you this. You talk about a shift to conditional steps for HSA's. Now that is a proposal you are making. What would be the circumstances of that shift? What would that mean?

Mr. CHAMPION. That would mean that if an HSA did not carry out its fundamental commitments under the Health Planning Act and, therefore, was not an effective instrument as that act contemplated it, that you could put them in effect on notice for a period of time by returning them to conditional status, thus affecting the function they could perform and their funding in the future.

Mr. SATTERFIELD. And if they stayed on conditional status and did not comply within that period of time, would you remove funding from them?

Mr. CHAMPION. That is correct.

Mr. SATTERFIELD. To get back to the point that I was making earlier, you do have a very high degree of control over the HSA's, you control the pursestrings.

Mr. CHAMPION. We believe that the act intended that the HSA should carry out the fundamental purposes that the Congress stated in the act and if they do not, the Federal Government would not want to spend money on them.

Mr. CARTER. Will you yield on that?

Mr. SATTERFIELD. Glad to yield.

Mr. CARTER. In your guidelines you mentioned their effects on HSA's but you did not mention that they should be based upon the law which we passed, the present act, the act of 1974.

Thank you for yielding, Mr. Satterfield.

Mr. SATTERFIELD. Mr. Chairman, I have a lot of questions but I've run out of time at this point but I would like to return to my line of questioning later.

Mr. ROGERS. Mr. Florio.

Mr. FLORIO. Thank you, Mr. Chairman.

I have some short specific questions and then two which require more elaboration.

You mentioned this particular need in the doctors' offices. I assume you are also talking about nonprofit corporations—doctors groups, radiology groups outside of hospitals.

Mr. CHAMPION. Yes. For equipment costing over $150,0000 I think, wherever it may be. We have ended up with CAT scanners on flat bed trucks in some cases.

Mr. FLORIO. That is the definition of major?

Mr. CHAMPION. That is my recollecton.

Mr. FLORIO. You mentioned there were other things in your recommended legislation that are coming down. Do any of those other things deal with HSA jurisdiction over Veterans hospital facilities?

Mr. CHAMPION. Not to my knowledge. No.

Mr. FLORIO. You have a provision—mandating 25 percent local elected official participation on the HSA board. At this point I have not made up my mind whether that is good or bad, but I think you probably have taken into consideration the opposition you are going to encounter with that kind of recommendation. If that is what you are doing, it is diminishing the providers sector and already many providers are very apprehensive about the HSA's, feeling they don't have sufficient input now. Dental groups around the country have said that they rarely get a chance to participate and they have a dentist or a nurse or whoever it happens to be.

Your recommendation is going to effectively diminish this. Have you anticipated that type of opposition?

Mr. CHAMPION. Yes, to some extent, although there may be specific groups that would more strongly oppose this. The fundamental notion is that while there should be provider representation, that providers basically are people who should be making their case to the governing body and should have full opportunity to do that. That they should have a certain percentage of the voting rights is another question altogether, and the committee's original decision was that there should be a consumer majority. We feel that the provider role is adequately taken care of by the fact that they have full access to provide information, to make statements, and to take positions.

They will have some providers on the body who can speak to the appropriateness and professsional terms. All of these groups tend to be well staffed, well provided with professsional advice and they can have an appropriate impact with no more than the amount of participation that this calls for. I assume that you are right, that the providers would wish to have more.

Mr. FLORIO. Just to amplify the point, I say I have to think through exactly whether it is socially desirable to have elected officials compose one-fourth of the members of the board, who have to respond to their constituents. We know that the most controversial questions are the ones that the elected officials would be the least able to evaluate so I reserve my rights to give that some more thought in terms of mandating 25 percent of the HSA's.

Mr. CHAMPION. I might add there is another element here which I did not mention and that is the PSRO. We now have more agreement with PSRO's to provide a very heavy element of professional advice, because those are professionally oriented agencies.

Mr. FLORIO. I'd like to counter that, the advice and the ability to consult is something that is very important but we have made a statutory decision that 51 percent are going to be consumers who theoretically are not supposed to have a particular axe to grind. The real crux of the problem gets down to the decisionmaking. There is a lot of information that comes in, much of it in direct conflict. If we are going to have an objective group making the decisions I am not sure that elected officials should be weighted in terms to make these decisions.

You mentioned modernization grants and modernization funds. Do you recall if the HSA's as currently have jurisdiction to pass those

grants and then sign off on applications that are being made for position moneys?

Mr. CHAMPION. Yes, I think that they do have to pass on them. I don't know whether that is the controlling—they do not have a controlling voice, do they? No, it is advisory.

Mr. CARTER. Mr. Chairman, if the gentleman will yield.

Mr. FLORIO. Yes.

Mr. CARTER. The HSA was given the authority to make that determination, in fact for all health care in that area.

If you would permit me further.

Mr. FLORIO. Sure.

Mr. CARTER. You are proposing that 25 percent of the board be elected officials and that share would be subtracted from the providers, as I understand it. You know that any elected official who is in on HSA board he is going to want to improve his own hospital or health facility in his own area. This to me is a very, very controversial amendment, as I see it, and it takes away from the wonderful people that we now have in our HSA's, and they are a great group.

Mr. FLORIO. If I could continue.

After consulting, do you assume that HSA has an advisory responsibility, that they have to advise HEW with regard to the modernization grant?

Mr. CHAMPION. That is correct. The final approval authority is with the Secretary. Obviously, that is a very strong recommendation, but our understanding is that that is an advisory and recommendation capacity, not a final decision.

Mr. FLORIO. Has this been recently arrived at? My reason for asking is that within the last month or so he has indicated that he has been notified and they regarded it as a signoff. That is the phraseology which they use. They are required to sign off on applications for modernization. This particular HSA perceives this as the opportunity to look into the whole question of the accounting procedures—the hospital, the administrative costs of the hospital—saying if in fact Federal money and modernization are going to be utilized there is a responsibility to see that the hospital is using those moneys in the most cost effective way. If they have wasteful billing practices or if they have duplication of laundry services it is something that should be brought to the attention of the hospital when it comes and ask for modernization money. The implication being that unless they change their practices the HSA will not sign off the modernization grant. Therefore, HEW would be inclined not to approve the modernization grant.

Mr. CHAMPION. I think the word "inclined" is correct. I think that reading generally is correct. All I am saying is that the ultimate authority rests in the Secretary and if a hospital wants to come back against a negative recommendation, that is a question that can be raised with HEW in applying for the grant. But we certainly would want to make sure that what HSA's mean by signoff is that they have reviewed it and that we know their views and recommendations, and that some people would understand that we would be strongly inclined to accept the HSA verdict on that subject.

Mr. FLORIO. Mr. Chairman, before I go to the last question let me make an observation and identify what Mr. Satterfield's concern is.

In many respects we are drawing a very generalized piece of legislation, we are improving, hopefully, a generalized piece of legislation. Tremendous amounts of discretion are given to the Secretary and the various agencies. The rulemaking procedure is going to have to be improved an awful lot if you are not going to have the tremendous traumatic events occurring around the country.

The Secretary would be well advised to reach out as much as possible and attempt to consult with this committee even in regard to the rulemaking process though that is normally not the case. I regard this as a most important piece of legislation which is going to come out of this committee.

The administration has signaled that the national health insurance program is not going to be dealt with by this Congress. I happen to believe that this is more important. Is that admittedly an arbitrary approach, is it a short-term approach, is it a long-term approach? Unless we are going to live with these constant controversies over interpretation of the rules, the rulemaking process has got to be improved.

The last point I would like to bring into contest, concerns my own area. There is a controversy where the "B" agency has made a recommendation for the certificate-of-need for a particular facility. The "A" agency has rejected that recommendation and issued a certificate-of-need to a competing hospital. We have two hospitals competing. That is the problem we have in our area. It is my understanding that in Massachusetts—I was there not too long ago—they have a different type of a problem dealing with the same general controversy. We in the A and the B agencies agree that their particular need is not appropriate but the applicants have gone to the State Legislature and had a piece of legislation introduced.

In essence what I am asking you, is whether this is happening around the country? That the certificate-of-need process and the integrity of that process, is being thwarted either internally between the two agencies or by external agencies coming in?

Mr. Champion. Let me answer your first question just briefly first, and tell you that we agree with you about the sensitive part and the need to improve the rulemaking process. The reaction we have had to redoing it in the guidelines would indicate a general satisfaction with that approach and we would hope to continue to have the broadest kind of consultation.

Mr. Florio. On that one point you may regard this as being unfair but, Mr. Satterfield, I think we accept the same procedural deficiencies. I am of the opinion that HEW should have more control over what is going on and yet I am saying that the control should be rationally arrived at. I want to see guidelines that are specific but I don't want to see someone just making them up without an opportunity for a consensus. I don't think we should have these plans all over. There should be some national guidelines, but the national guidelines have to be arrived at as a result of the consensus process.

Mr. Champion. I agree not only with that but we should very carefully explain what that process has been and how the conclusions finally put forward have been arrived at. That we failed to do the first time around.

I think the new proposal does explain in great detail where the standards came from, which professional society propounded them, what factors were taken into consideration in arriving at them. I think we need to do that and I concur with you entirely.

With respect to the other question about the problems of certificate-of-need, I don't know how widespread that problem is coming to be but there is no question that it is very serious in a number of places, including the Massachusetts situation. Over the Governor's veto, the State legislature approved two certificates-of-need, that in effect gave two hospitals the ability to go ahead despite the whole administrative process leading up to it, and neither there nor in the other cases of which you speak is there any real ability on the part of the Federal Government to deal with that.

There is a situation in Ohio where the State overturned an HSA, in our view without satisfactorily supporting their reason for so doing. We can argue, but under either certificate-of-need or 1122 there is really very little that we can do except ultimately to change the funding of the agency responsible. We cannot, for instance, use the withholding of Federal reimbursement. There is very little we can do when that takes place and the committee may want to look at that situation.

Mr. Florio. Thank you, Mr. Chairman.

Mr. Rogers. Well, as I understand it, in issuing the revised guidelines you have provided for additional time for public comment so that no one can say they were not consulted.

Mr. Champion. That is correct, Mr. Chairman, and we have repeated the whole process.

Mr. Rogers. The whole process is to assure that everybody has a right to be heard and I commend you for it.

Also, as I recall the law, the whole theory is to let the local people try to decide and make judgments as to whether new services and facilities are needed in their areas. They have the right to review and approve these projects.

Mr. Carter. Mr. Chairman, I want to agree on that.

Mr. Rogers. That is what we wanted and if the HSA disapproves the funding of a project coming into their area, so state its reasons.

Now the Secretary has ultimate authority on the approval of Federal funds.

Mr. Champion. Only on the Federal funds.

Mr. Rogers. We want to be able to hold him accountable so he would have to issue reasons why he felt it was appropriate to proceed if the local HSA says, no, we don't want those funds here. So I think it is clear that we want to get local plans and assure that the local people are involved.

Now let me ask you this. The recent study of the General Accounting Office points to some management problems in the health planning program. Now they point out, for instance, that there are eight authorize GS–15 positions and yet there were 18 GS–15's employed by the Bureau of Health Planning and Resource Development at the time of the review.

Now this surely must have been known to the administration and the prior administration but I don't know what has been done to solve it. Has any action been taken?

Mr. CHAMPION. I will ask Dr. Foley to respond.

Mr. ROGERS. Certainly.

Dr. FOLEY. Mr. Chairman, we are reorganizing Bureau of Health Planning and Resources Development. It was announced in the Federal Register in December of 1977. We are also recutting every job description within that Bureau. Grades will be appropriately allocated so that the job can be done. That will be completed by the end of March of this year.

As you are probably aware, we expect some litigation with some of the staff in that situation. We are attempting to work through the Public Health Service with the Health Resource Administration to be equitable to the employees and at the same time meet the concerns that were reflected here in the GAO report.

Mr. ROGERS. How many employees of the Bureau of Health Planning Resources Development have worked in the area-wide or State planning agencies previously? Very many?

Dr. FOLEY. One, Mr. Chairman. We are considering placing some of those current staff out in the field for at least 3 months, perhaps even longer. Since we have under the Civil Service procedures here in the Federal Government a way of paying for that, I think it is very important for the staff in this particular Bureau to have local and State experience.

Mr. ROGERS. Now if you think there are needed changes in the law, any suggestions you have would be helpful to the committee. Try to bring in more people who had experience with local planning so we can relate a little better.

Now I understand you are proposing that we do away with the per capita funding formula for HSA's which is currently in title XV. As I recall we gave you flexibility for the State Health Planning and Development Agencies but you adopted a formula in regulations. I am not sure that I understand what you really want. You want to set the formula and not have us do it is that it?

Mr. CHAMPION. No, Mr. Chairman. What we would like to have is some ability to recognize good work and to signal bad work, and also the ability, as these agencies take on certain functions and perform them and have heavier workloads in connection with certificate-of-need or other things, to expand funding where appropriate. As a matter of fact, we would propose to continue the current system for now.

I think there has been a legitimate criticism of the capacity of regional offices to make good judgments about what funding levels should be, and under the circumstances we feel perhaps that is right to continue the current system. You will notice in my statement I said that when we had the ability to make sophisticated judgments, we would like to proceed, and we are thus seeking an amendment for the future, not for the present.

Mr. ROGERS. I wonder if it would not be well to require the submis- of budgets from the HSA's and allow you to fund those up to the level set by a formula.

Mr. CHAMPION. We are now approaching, as you know, the ceiling of the formula. I think the formula we are within——

Mr. ROGERS. I am not sure that all of those moneys are needed by all of the agencies. That is what I am saying. I think a look at a budget may show there is real waste in some areas and just turning over an amount of money which I know we directed to get them started is not wise. I think that was about the only way we could do it to get them started but maybe we are at the point where we should require the submisison of a budget.

Mr. CHAMPION. Mr. Chairman, it would be nice to look at a budget, but we would have a problem negotiating an entire budget. We have had problems where people have tried to control too closely local HSA activities. They would argue whether an administrator should be paid $28,000 or $30,000, and we don't think the Federal Government should get into that level of consideration. But examining the amount of money to do what they are performing in terms of functions, a functional kind of budget, would make a great deal of sense.

Mr. ROGERS. Suppose they have a budget and they have a rather small health service area and they don't need much money for travel but they have a huge amount in their budget for travel. In other words, I think we want to be reasonable but I think by asking for a budget it would also require some thoughtful oversight by the HSA itself on its own spending practices.

So I would like to have your thinking on that for the record when you have an opportunity to comply.

Mr. CHAMPION. We will respond to that. The tension there is how much paperwork.

Mr. ROGERS. I understand that.

I presume they draw up the budget to cover that anyhow.

Mr. CHAMPION. I would hope so, too, sir.

Mr. ROGERS. The main focus of the Department's testimony is on cost containment—well, it is on cost containment and reducing services but what about resource development and providing services that are not available to those who don't have access to them?

Now I question whether we are emphasizing a proper balance of concerns. I don't see that you propose any regulations or funding of the area of health service development funding.

Mr. CHAMPION. I know of none.

Do you know Dr. Foley?

Mr. ROGERS. Why not?

Mr. CHAMPION. I am told that there is nothing directly here for that purpose except that we did recommend substantial expansion of community health centers.

Mr. ROGERS. I don't even see it listed as coming up for rulemaking. Shouldn't it be? In your status report on health planning regulations, appendix 1 to your statement [see p. 61], I see no area health service program set forth.

Mr. CHAMPION. Well, that being the case, Mr. Chairman, there should be. I will look into that and I will respond to you on the record with respect to that.

[The following information was received for the record:]

The drafting of proposed AHSDF regulations is underway in the Bureau of Health Planning and Resources Development. We anticipate that a NPRM will be published later this spring, with final regulations scheduled to be issued this summer.

Several factors have contributed to the delay in developing these regulations. No funds have been appropriated to date under section 1640, and indeed until fully designated, HSAs are not eligible to receive area health services development funds. It was only last fall that the first agencies received full designation, and to date only nine HSAs have been fully designated. This coupled with the increasing pressure to get other more urgently needed regulations issued, such as the final State agency regulations and NPRMs on review and approval and appropriateness review, led us to defer development of AHSDF regulations until recently.

Mr. ROGERS. One of the purposes of these agencies is to say we don't have a service here and we want it and need it. HSA's are to see quality health services available and I think we need to stress that.

Mr. CHAMPION. We will respond formally. You are right, sir.

Mr. ROGERS. Thank you.

[The following information was received for the record:]

We agree that "gaps" in existing health services may from time time and place to place be identified by some HSA's. Furthermore, their responsibilities include improving the availability and quality of care as well as eliminating unneeded or inappropriate duplication of services.

However, we feel that cost containment is the more urgent problem that State and local health planning agencies must address at this time. For if we ever are to provide adequate health care resources and services in areas and to populations where "gaps" may now exist, we must begin to curb unnecessary and expensive duplication.

Support for many of the kinds of developmental efforts that may be identified as needed by HSA's in their areas, are available through other already existing Federal health programs such as the community mental health center and family health center programs, the HMO program, various maternal and child health programs, and the migrant health project grant program. As the following table shows, appropriations for these have risen substantially in the last several years.

RECENT APPROPRIATIONS FOR SELECTED HEALTH PROGRAMS

[In millions]

Program	Fiscal year 1977	Fiscal year 1978	Fiscal year 1979 [1]
Community health centers program	$142.9	$247.0	$301.0
Community mental health centers program	126.5	269.0	284.1
Family planning grants	82.7	125.0	145.0
HMO grants	18.1	21.2	25.9
Maternal and child health program	275.1	364.7	377.7
Migrant health project grants	19.3	34.5	34.5

[1] President's budget request.

Moreover, we are not convinced that HSAs will in the next year or two have pressing need for Area Health Service Development Funds. Not only are other funds available, but also there is no experience to suggest that the other tools available to HSA's to promote resource development activities—for example, publication of specific plans and projects for their Annual Implementation Plans, implementation of those plans, and the technical assistance—will not spur the development which HSA's determine necessary to achieve their objectives.

We would, however, reexamine this question again when there is more substantial body of operating experience with respect to HSA plan implementation. If a clear need specifically is demonstrated for Area Health Service Development Fund, we would request such funds at that time.

Mr. ROGERS. Of course, you mention the coordination with the SMSA's in other areas. I think it would be helpful to have any suggested legislative changes that you think that is required.

As I recall there are 12 single State health service areas that have been designated.

Mr. CHAMPION. That is my recollection.

Mr. ROGERS. Now do we need any changes in the law to reconcile any duplication of effort or overlap of responsibility between the State and the HSA in those States? You might let us have your thinking on that for the record.

[The following material was received for the record:]

With respect to the coordination among health systems agencies (HSAs) serving the same Standard Metropolitan Statistical Area (SMSA), we believe that section 222 as proposed in H.R. 10460 would go a long way towards achieving the kind of coordination needed. Section 222 would require the several HSAs serving a split SMSA to coordinate certain important activities or functions--plan development, their review criteria, and certificate-of-need reviews and recommendations--in accordance with an agreed upon plan approved by the Secretary.

As you know, 36 of the 270-odd SMSAs in the country were split as the result of waivers approved by the Secretary and the granting of section 1536 status to the District of Columbia and Rhode Island. They are:

Allentown-Bethlehem-Easton
Boston
Bridgeport
Chicago
Cincinnati
Clarksville-Hopkinsville
Evansville
Fall River
Fort Smith
Hartford
Huntington-Ashland
Lansing-East Lansing
Lawrence-Haverhill
Louisville
Lowell
Memphis
Minneapolis-St. Paul
New Haven
New London-Norwich
New York City
Norfolk
Northeast Pennsylvania
Parkerburg-Marietta
Philadelphia
Portland (Ore.)
Providence-Warwick-Pawtucket
Rochester
San Fancisco-Oakland
Springfield-Chicopee-Holyhoke
Steubenville-Wierton
Texarkana
Toledo
Washington, D.C.
Wheeling
Wilmington
Worchester

These 36 split SMSAs include six major metropolitan regions containing approximately 23 million people or over 10 percent of the total population of the United States: Boston, Chicage, Memphis, Philadelphia, San Francisco-Oakland, and Washington, D.C. Three of those--Memphis, Philadelphia, and Washington, D.C.--are lare interstate SMSAs.

Our present regulations regarding the designation and funding of HSAs require that a conditionally designated agency shall coordinate and seek to enter into a written agreement with other designated agencies serving health service areas within the same SMSA. Such agreements shall as a minimum include provisions for review and comment on each others HSPs and AIPs, joint review of projects, exchange of information on activities affecting the SMSA, and the sharing of data. These regulations, however, fail to provide either incentives or sanctions, short of non-renewal or termination, mandating the effective meshing of plans, joint certificate-of-need reviews, sharing of data, and the like.

Section 222 and other changes proposed by H.R. 10460 would be most helpful in assuring that important health planning issues which cross health service area boundaries, and sometimes State lines, are adequately and effectively dealth with. We also would suggest:

- The coordination requirements of section 222 be broadened to include sharing of data and information.

- Coordinating responsibilities and functions be expanded to incude State health planning and development agencies in the case of split interstate SMSAs such as Philadelphia and Washington, D.C.

- HSAs serving split SMSAs explicitly be authorized to delegate certain review responsibilities to such inter-HSA coordinating bodies or mechanisms as may be required to achieve effective cooperation and integration.

* * * * * * *

The issues surrounding single State health systems agencies has been of concern to the Department since the intital designation of 12 statewide health service areas and the subsequent designation of HSAs in those States. The States in question are:

Delaware	Oklahoma
Idaho	Puerto Rico
Maine	South Dakota
Mississippi	Vermont
Montana	West Virginia
New Hampshire	Wyoming

Therefore, the Bureau of Health Planning and Resources Development last year instituted a contract with Arthur D. Little, Inc. to evaluate single State HSAs (and so-called section 1536 States).

Their final report of that Study of Single HSA States and Section 1536 States was submitted in late January, and it has been shared with staff of both the House Subcommittee on Health and the Environment and

the Senate Subcommittee on Health and Scientific Research. One major conclusion was that, "The single HSA structure is workable and has the potential to meet the objectives of P.L. 93-641 without unnecessary duplication, and where it results in conflict, this conflict is often consturctive."

The Arthur D. Little study and report included a number of recommendations, including several proposed legislative changes, to overcome current inadequacies and concerns with respcet to single HSA States. These were:

1. Allowing single statewide health service areas, to the extent practicable, (1) to include no more than one center for the provision of highly specialized health services, and (2) to have a population of less than 1,500,000.

2. Requiring in single HSA States that there be separate and identifiable SHCC with 40 percent of its members composed of gubernatorial nominees, precluding the option of the governor appointing all or part of the HSA governing body as the entire SHCC.

3. Encouraging of subarea advisory councils in a single HSA States, with additional financial resources made available to these HSAs for support of such councils.

4. Authorizing special funding supplements for statewide HSAs beyond the basic grant provided by the current formula.

While neither the Department nor BHPRD have had time to thoroughly review this report, we do have some reactions. The first, which would revise the criteria for establishing health service areas with particular reference to

statewide areas if it were to be adopted. Several of the 12 current statewide areas have more than one center for the provision of highly specialized health services, and four single HSA States have populations over 1.5 million (i.e., Mississippi, Oklahoma, Puerto Rico, and West Virginia).

We support the second recommendation which, in effect, would preclude the governing bocy of a single statewide HSA and the Statewide Health Coordinating Council from having identical memberships. This situation presently exists in four of the single HSA States.

The last two recommended changes are, we believe, unnecessary if the discretionary funding provisions, either as proposed in the Administration's bill or H.R. 10460, were adopted.

Mr. ROGERS. We have recently passed amendments allowing an extra 12 months for conditional designation of HSA's. How many agencies do you expect to not be performing adequately and, therefore, be terminated instead of being fully designated? Is there any thinking on that now?

Mr. CHAMPION. I would not offer such a number. Dr. Foley may have something.

Dr. FOLEY. We are currently, Mr. Chairman, negotiating with a couple of HSA's trying to put them on a work plan to meet certain conditions.

At this point we do not have any specific agency in mind for possible defunding. However, if the specific agencies that I have in mind do not meet the conditions, we might be back in 2 years telling you that we had defunded a couple.

Mr. ROGERS. All right.

Any other questions?

Mr. CARTER. Yes.

The General Accounting Office has stated that the Bureau of Health Planning for Resources Development is troubled with the problems of an employee morale, lack of appropriate job restrictions and poor communication among the various divisions and offices within the bureau. Could you comment on their statements in this regard?

Mr. CHAMPION. Again, I will speak generally and ask Dr. Foley to provide the details.

There has been a continuing problem there and we have tried under the current organization to clear that up, as Dr.Foley said earlier, but I regard that as an appropriate comment by the GAO on the past state of things.

Mr. CARTER. What is the suggestion?

Mr. CHAMPION. I would only add, Dr. Carter, that we intend basically to meet the requirements, give adequate training to the staff, also consider the possibility the chairman has raised in moving people out into the field by the end of March of this year. We do expect, however, because of the sensitivity of the past problems, a few law suits, but we continue to move ahead anyway.

Mr. CARTER. When does the Department expect to complete their regulations?

Mr. CHAMPION. We have a schedule which we have appended. I think the basic regulations will all be out by June, is that correct?

Mr. CARTER. Why is it taking so long?

Mr. CHAMPION. In effect, part of the discussion we had with respect to the national health guidelines, not very much progress had been made before we took this job. As we get into these questions specifically, and as the ones that you have just seen, we have gone through so many new questions, so much consultation, the more consultation and the more attempt to achieve concensus the longer it takes. We are committed to not letting that process become endless as it had seemed to be until this year, but to bring the questions to a head and try to deal with them.

When we came into the Department nothing had been done and they had had this before them for 2 years. We in effect started all over again this year.

Mr. CARTER. I notice that you are changing the formula for representation on the HSA Board, I believe, from 51 percent consumers to 57 percent consumers. Is that correct?

Mr. CHAMPION. Maintain the——

Mr. CARTER. I thought the present law was 51–49.

Mr. CHAMPION. We have said maintain a majority of consumers without counting the public officials. That is the proposal.

Mr. CARTER. The public officials would be considered as part of the provider share, is that correct?

Mr. CHAMPION. No, they would be a separate category.

Mr. CARTER. Twenty-five percent?

Mr. CHAMPION. Twenty-five percent.

Mr. CARTER. All right. What would the other percentages be then?

Mr. CHAMPION. That would mean if the majority consisted of 51, I think the current majority consists of 53 but it would be somewhere between 20 and 25 percent providers under our proposal.

Mr. CARTER. You would take the providers down to 23 to 25 percent of the total?

Mr. CHAMPION. That is correct.

Mr. CARTER. We do have complaints throughout the entire country that there has not been adequate representation of MD's and dentists. I think that they should both be represented.

Now something was mentioned about national health insurance and the basis for it. Actually I believe that 90 percent of the physicians and dentists and OD's in this country would provide such services as happened to be necessary to any person who came to their offices or clinics, and personally I would not be adverse to seeing that those who received public funds be so required.

Furthermore, I believe that the profession feels that everyone under the poverty level should be taken care of and that in case of catastrophic illnesses, if medical payments in the case of one person reaches $1,500 or in the case of a couple goes to $2,000, then the Government should take over. Those who are employed could be insured by their employers and those who are self-employed could buy into this insurance proposal. Employers who are marginal could be assisted by the Federal Government in this program.

Why is it, Mr. Champion, that you have not gone ahead with such a program as this to provide assistance to poor people all over this country? I mean health assistance, medical attention for them? Why is it you delay on this national health insurance plan? We were promised, we were told that we would have some such plan last year. Last year has come and gone and now we are told that such plan will not be forthcoming this year. When will it be forthcoming?

Mr. CHAMPION. Dr. Carter, we did not—by "we" I mean the administration—we did not say that we would have a national health program last year. We did say we will have one this year. We will have one this year. There will be a set of principles announced early this spring and there will be legislation coming to the Congress, and that comports with what the administration has promised in this field.

Mr. CARTER. Is that statement correct about last year or not? Weren't we told that?

It is my understanding that the people were told that last year.

Mr. CHAMPION. Dr. Carter, that is not my recollection.

Mr. CARTER. It seems to me that it was part of a certain party's platform.

Thank you.

Mr. CHAMPION. They don't write many dates in platforms, sir.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Satterfield.

Mr. SATTERFIELD. Mr. Chairman, I would like to continue the line of questioning that I was involved in earlier.

I made a statement, or asked a question at least, didn't HEW really have final say so and approval of the State plan and you answered no. I think technically you are correct.

Let me now go back to what I was talking about. If I read this statute right, under section 1515 you enter into a contract with an HSA and if I read correctly subsection C(1)(b) the Secretary has a right to terminate that contract whenever he determines that the entity is not complying with or effectively carrying out the provisions of the agreement. It provides that a part of the conditions of that agreement be those functions of an HSA that are spelled out in section 1513.

Now I would like to ask this question. If you revoke the contract of an HSA, what happens then? Do you go about bringing a new HSA into being and recognizing it?

Mr. CHAMPION. That would be the normal process.

Mr. SATTERFIELD. I go back to my original question and the point that if an HSA does not come up with a plan fully comporting with the requirements of the guidelines, the Secretary does then have the right to terminate his agreement with that HSA and put another one in place, does he not?

Mr. CHAMPION. Yes, but those are not the only considerations.

Mr. SATTERFIELD. I know they are not the only considerations.

Mr. CHAMPION. He has the right under the statute to terminate. These are the guidelines, they are not directives. It does not say that in order to meet those requirements, they have to do everything that those guidelines set forth.

Mr. SATTERFIELD. Don't those guidelines say that the HSA shall incorporate them within its plan within a period of 1 year, and don't they also say that the plans have to be in place and be performed in a period of an additional 4 years?

Mr. CHAMPION. The guidelines say they have to take account of them in their plans, after looking at these guidelines, and the benchmarks they set forth, beginning with plans written 1 year after their promulgation. These are not directives, they do not have to be put in. There are all kinds of permissions for adjustments and judgment by the HSA's and we are looking at their general performance, not the specific.

Mr. SATTERFIELD. If the Secretary concludes that they are not conforming with those guidelines, he has the right to terminate the agreement and appoint a new HSA, and I think that that power speaks for itself.

Mr. CHAMPION. There is nothing that says that that is the only consideration or that he would do that.

Mr. SATTERFIELD. There is nothing that says he cannot do that either, is there?

Mr. CHAMPION. There is not.

Mr. SATTERFIELD. When I asked the question about cost control and limiting the revenues of facilities, you said under the Act you did not believe you had the right to do that but you thought the way to do it would be to issue guidelines. My question is that if you issue guidelines including provisions contained in the Hospital Cost Containment bill and an HSA refuses to comply with those guidelines to the satisfaction of the Secretary, the Secretary can terminate the contract with that HSA and go about recognizing another one and do this ad infinitum until he gets one that satisfies him, is that not correct? Can he not do that under this act?

Mr. CHAMPION. I think that is theoretically possible, although I think under my understanding of the act as it is written that the Secretary would be going beyond the intention of this act. Therefore, while it may theoretically, by some series of constructs be possible, I don't think that that result would be—

Mr. SATTERFIELD. Could you point out the language in that act that would indicate that this would be going beyond the intent of the act?

Mr. CHAMPION. No, not specifically. I don't think the act takes account of all hypotheses.

Mr. SATTERFIELD. I am not concerned about what is likely to happen. I am very concerned in drafting legislation about what may possibly be done and in that sense this act bothers me.

I would like to ask another question in connection with that point. You made a recommend in your statement on page 19 that in order to improve the situation that you "would require the Governor to formally approve that plan after it has been developed and revised by the SHPDA and the SHCC." I am not really sure what you mean there. Are you saying that the Governor has to approve it or would the Governor have a right not to approve it?

Mr. CHAMPION. The Governor has a right not to approve it, to send it back. In effect he does not change a provision, it is just that he approves the overall act.

Mr. SATTERFIELD. What is the reason or bringing the Governor personally into this process?

Mr. CHAMPION. If there is something that he finds unsatisfactory, he could send it back for further discussion to a State health coordinating council to work out.

Mr. SATTERFIELD. Isn't it also designed to give the Secretary a little bit more leverage over the Governor?

Mr. CHAMPION. No. As a matter of fact, this request came from the National Governors Council.

Mr. SATTERFIELD. Let me go a little further on that. On local participation you want 25 percent of the HSA governing body to be made up of local elected officials. Why?

Mr. CHAMPION. Basically because we found that where you work well with local and State elected officials you represent all of the people in that area rather than specific providers; even the way in which consumers have been chosen, often is not sufficient to bring into the board an element that puts it on a realistic basis in the local community.

Mr. SATTERFIELD. Isn't it a fact that the proposals you have made and are making to close facilities, and to require certiffcates-of-need for all new facilities will require State and local legislation for implementation?

Mr. CHAMPION. That is why we think that recomendations that come from a group of substantial local officials will carry real weight when those decisions are made at other levels of government.

Mr. SATTERFIELD. Wouldn't the converse also be true, that since you have 25 percent of the governing body made up of elected officials and since the Secretary has ultimate control of the approval of the plan or the termination of the contract with that HSA—does this not deliver to the Secretary of HEW a degree of control or undue influence over local elected officials?

Mr. CHAMPION. I would not agree.

Mr. SATTERFIELD. Well——

Mr. CHAMPION. The local elected officials of counties and others have asked for this. We already have 15 percent. We are talking about a change to 25 percent.

Mr. SATTERFIELD. Dr. Carter brought up a question about HMO's and I would like to pursue that for a moment. The hospital cost containment that is presently approved, those hospital facilities that participate basically in HMO's are exempted from its provisions both as to limitation of revenues and limitation on county construction money, am I correct?

Mr. CHAMPION. That is correct.

Mr. SATTERFIELD. Now you come along and suggest on page 18 that you want to exempt HMO's from the current provisions dealing with certificate-of-need requirements, and I wonder why.

Mr. CHAMPION. In establishing an HMO it is now required that they meet certificate-of-need. You could establish another service such as a group practice, without getting a certificate-of-need. It is an added requirement now on an HMO. We are simply asking in this case that HMO's be brought into the same posture as anybody else.

Mr. SATTERFIELD. If you stop right there, I would agree with you but you go on to say you would promulgate regulations to limit planning agencies' review of HMO construction projects. Now when you put those two proposals together you have a horse of another color.

Mr. CHAMPION. The second part has to do with which criteria are appropriate for HMO's. They come into a scene which is already set in effect and they need facilities. We would hope that they could get those facilities through bargaining for excess capacity in the present system but we would not like to see HMO's be in the posture that in effect they can be shut out by the present system without having appropriate facilities, and, therefore, we think we need some special recognition of their special problems.

Mr. SATTERFIELD. How would HMO facilities then fit into your guidelines? You are saying that you should have a certain number of beds for a certain population. You are saying to the HSA's that they are going to have to close down beds and facilities to reach that level and that no new facilities can be brought on line unless that level is maintained, but any facility connected with an HMO, whether it be a hospital or something else, the Secretary can decide to build

it where he wants and when and why. If he does, does this not figure into the guideline requirement of four beds per 1,000 population and isn't that going to force the HSA to close down more beds in other hospitals?

Mr. CHAMPION. We have asked the HSA's to give consideration, we have not asked that they be removed from the process.

Mr. SATTERFIELD. I think you are removing them from the process when you give them the right to build new facilities. I don't know why the new hospital as part of an HMO should be treated any differently. If you are going to limit the beds to four per 1,000, why remove a hospital that is going to be a part of an HMO?

Mr. CHAMPION. Let me give you an example. We have in the District of Columbia efforts by an HMO to acquire excess capacity to use for their purposes. The system is not yielding that excess capacity to them and we think special leverage is needed to get that done.

Mr. SATTERFIELD. Why?

Mr. CHAMPION. Because we think HMO's are not only good quality but cost effective and the Congress has passed legislation which indicates the same belief.

Mr. SATTERFIELD. I conceive then——

Mr. CHAMPION. We don't believe they should be shut out by a local planning process.

Mr. SATTERFIELD. What you are saying then is that under the guidelines you have and under the health plans now in place and as you have suggested be amended that we are going to gradually shut down hospitals already in existence and the Government will come in and finance HMO facilities which in time are going to replace everything we have today. Isn't that what is going to happen?

Mr. CHAMPION. No.

Mr. SATTERFIELD. It can happen.

Mr. CHAMPION. Theoretically almost anything can happen but that could not in my judgment practically happen.

Mr. SATTERFIELD. Is it not a fact that the HMO is the preferred system in HEW to replace the present health delivery system? Isn't that a fact?

Mr. CHAMPION. They would have to play a much more prominent role.

Mr. SATTERFIELD. I suspect it is much more than a prominent role and I suspect that these proposals you are making are going to enable it to take over, and I think we should be cautious and careful about that.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Florio.

Mr. FLORIO. Mr. Champion, now the dilemma is that all the answers you gave to Mr. Sattereld to make him less apprehensive make me more apprehensive.

I think it is more than just to acknowledge the fact that you are attempting to tilt toward HMO's. I agree with it but I can understand that some would not agree with it.

Mr. CHAMPION. I think I said that.

Mr. FLORIO. The fact is when you acknowledge that the Governor is going to play a more significant role, I think it is important to

be candid and say that you are giving the Governor veto power over particular plans. The expectation is that the Governor will make his reasons for vetoing, so to speak, public with the implication that the HSA's will then respond in a meaningful way to the reasons that are put forth for the veto, again with the expectation that the Governor rightly or wrongly in charge of an entire area—that is the State—is going to have a different perspective than perhaps the HSA.

My difficulty with the 25 percent local input is that you almost are building conflict into the system and this system does not need more conflict. What you are doing is giving local officials, who have more to say about what happens at the local area, an inclination to be somewhat provincial, and then saying that we are going to push it up to an authority, in this case the Governor, who we expect will not be as provincial and will think on a more area-wide basis. You are building in a sense a conflict that I don't think is needed.

Mr. Champion. Well, there are very many different local and State situations in this country. That is not the intention. It is our belief that in many places the counties have at least as much incentive and in some cases more to try to work out cost containment.

If you look at a place like Los Angeles, for instance, which has in excess of $50 million a year, the county in that case is a very important element in persuading the State toward effective cost containment. I concede that almost any solution, any percentages you may allocate, would have somewhat different effects. It is our judgment on the whole that the 15 percent has been useful and that some more might be more useful.

I would not argue that that is a universally applicable notion, but there is no leeway given to many special local circumstances.

Mr. Florio. Unless we over glorify the business community at the local area.

Let me give you an example. In my own area, it is a very important part of the need to enact antigun bill legislation as a part of the whole safety health protection, I think this is just sort of a tortured approach in terms of health. I don't think that should be contingent upon gun control legislation being adopted by the State. There is a need for a higher opportunity to review what is important and is not important.

I would not want to see you proceed in the way you proceeded in your responses to Mr. Satterfield by diminishing the significance of national guidelines, and in some way not giving the Governor the appropriate authority. That is what the Governor should have to look at, things from something more than just the local level.

The HSA concept is good, the consumer input is necessary, but we cannot very well write in stone the fact that the local HSA's are always going to respond in the most cost effective way possible because that has just not been the experience up to this point.

Mr. Champion. Mr. Florio, I did not in any of my responses to Mr. Satterfield change one bit our recommendations. Our recommendations are as we presented them to you today. The fact is that we don't think that there is any special wisdom at any level of

government—county, State, or Federal. Our proposals are based in an attempt to balance those not only in terms of the way in which they are formulated but in the way that engages all of those elements of government in carrying them out because we are here talking only about a planning process. Unless that planning process conforms to what can actually be done, then it is not going to serve us very well.

I hold no special brief for our particular approach. We think that these percentages are appropriate, but their purpose is simply to balance the Federal, State, and local levels to bring them together to have an effective planning process which stands a good chance of actually being carried out.

I hope that nothing that I said to Mr. Satterfield would indicate that we have retreated in any way from that attempt; we have not.

Mr. FLORIO. Thank you.

Mr. ROGERS. Let me just ask one question and Dr. Carter has two.

How many are working on the national guidelines, any more than the two people that we had before?

Mr. CHAMPION. At one point most of the Department, Mr. Chairman.

I will let Dr. Foley answer in more detail.

Mr. ROGERS. All right.

Dr. FOLEY. Mr. Chairman, we have more than two persons. We have the whole Bureau engaged in a functional sense. In my office, three people are involved as are other parts of the Department. We hav a task force that is cochaired by myself and a special assistant to the Under Secretary, Mr. Corbett, that involves approximately 20 people.

Mr. ROGERS. Set forth for us in the record exactly the setup there and who they are.

Dr. FOLEY. I would be glad to.

[The following material was received for the record:]

HEALTH RESOURCES ADMINISTRATION STAFF

In addition to Health Resources Administration staff, there are currently four individuals detailed from other Public Health Service agencies working on a full-time basis on the development of the National Guidelines for Health Planning. The individuals working on a full-time basis are listed below:

HRA—Robert Hutchings, Laurel Shannon, and John Bjerke.
ASH—Peter Solomon.
ADAMHA—John Biedenkapp.
CDC—Cal Jackson.
HSA—Rosemary Kerle.

These individuals are working under the direction of Daniel Zwick, an Associate Administrator of the Health Resources Administration, who is devoting the largest portion of his time to this activity. Supporting professional and secretarial assistance is being provided by the respective Agencies. Staff of the Bureau of Health Planning and Resources Development have also contributed to the development of the Guidelines.

In addition, a recently established Task Force on Health Planning, cochaired by Dr. Henry A. Foley, Administrator of the Health Resources Administration and Mr. Leo Corbett, Executive Assistant to the Under Secretary, and including members from various components of the Department, provides general policy advice on the health planning activities, including advice on the National Guidelines or Health Planning.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Mr. Chairman, I ask Mr. Champion how many excess beds do we have in the District of Columbia?

Mr. CHAMPION. I don't know that number. I will be glad to provide that for the record, Dr. Carter.

Mr. CARTER. Do you have an estimate or a guesstimate?

Mr. CHAMPION. I don't have

Mr. CARTER. Is there anyone in this group?

Mr. CHAMPION. The rough estimate is several hundred.

Mr. CARTER. Several hundred. And they are costing us how much each year—$30,000 for each empty bed?

Mr. CHAMPION. Our minimum is $20,000. It may very well be more than that.

Mr. CARTER. I believe $25,000 to $30,000; $30,000 is easily accepted.

You would take these excess beds in this case and convert them into HMO's, is that correct?

Mr. CHAMPION. Well, some of them we would like to see go to support HMO's, yes. I don't think it would take them all.

Mr. CARTER. Actually you want to retire excess beds in other areas even if you have to pay for them, is that not correct?

Mr. CHAMPION. Yes.

Mr. CARTER. You are following a different policy here.

Mr. CHAMPION. We would like to see some closed here as well.

Mr. CARTER. Getting the Governor in this, even though an HSA decides and the Statewide Health Coordinating Council goes along with a decision on the location of a hospital in a certain area or the placement of a CAT scanner in a certain area, when the plan comes up to the Governor he can veto that plan, according to your proposal, is that correct?

Mr. CHAMPION. Yes. Actually the word is that he can refuse to approve, which means it goes back for review.

Mr. CARTER. Refuse to approve. That means that he can locate hospitals or CAT scanners wherever he wants them throughout the State?

Mr. CHAMPION. No; it does not give him the authority.

Mr. CARTER. Well, he can refuse and he can refuse until he gets what he wants, is that it? If he does not get what he wants, he can refuse.

Mr. CHAMPION. Yes.

Mr. CARTER. Why not leave this up to the people, let them make the decision?

Thank you, Mr. Chairman.

Mr. ROGERS. I believe that concludes the questioning this morning. Thank you for being here with all of your associates. We will be in contact as we proceed to get perhaps additional information.

The committee has additional witnesses so we will recess the committee until 1:30 this afternoon.

Thank you for your presence.

Mr. CHAMPION. Thank you, Mr. Chairman.

[Whereupon, at 12:10 p.m. the subcommittee recessed, to reconvene at 1:30 p.m.]

AFTER RECESS

[The subcommittee reconvened at 1:45 p.m., Hon. Paul G. Rogers, chairman, presiding.]

Mr. ROGERS. The Subcommittee on Health and the Environment will continue its hearings on H.R. 10460, Health Planning and Resources Development Amendments of 1978.

The next witnesses will be from the General Accounting Office: Mr. James D. Martin, Deputy Director, Human Resources Division, accompanied by Mr. Carl Fenstermaker, Assistant Director, Human Resources Division, and Mr. William Gerkens, Supervisor, Auditor, Human Resources Division.

We welcome you gentlemen to the committee. We are pleased to have you.

Your statement will be made a part of the record in full [see p. 115], you may proceed as you desire.

STATEMENT OF JAMES D. MARTIN, DEPUTY DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY CARL FENSTERMAKER, ASSISTANT DIRECTOR; AND WILLIAM GERKENS, SUPERVISOR, AUDITOR

Mr. MARTIN. Thank you, Mr. Chairman.

Mr. ROGERS. It would be helpful if you can highlight the major points.

Mr. MARTIN. Yes, sir. We will do that.

Thank you very much.

We are pleased to be here today to discuss some of the problems we have identified in the implementation of the National Health Planning and Resources Development Act of 1974.

The organizational structures, health systems agencies, State health planning agencies, statewide coordinating councils, and regional centers for health planning are in place and operating throughout the country. A number of problems, however, need to be overcome before these organizations will have a significant impact on the rising cost of health care and the need for improved accessibility to quality care.

HRA's Bureau of Health Planning and Resources Development must act to finalize regulations and provide adequate guidance to the HEW regional offices as quickly as possible. Delays in providing instructions to the regions resulted in decisions being made regarding the implementation of the health planning act which appear to be inconsistent with initial Bureau guidelines. Moreover, these delays also may have caused inconsistent implementation of the planning program throughout the country.

The organizational problems experienced by the Bureau need to be remedied as soon as possible to insure the orderly implementation of the health planning program.

The large amount of litigation regarding the act has tied up Bureau personnel and resources and has been responsible for some of the delay in implementing the health planning program. Resolution

of the various legal challenges to the act and the way it is being implemented could have a significant impact on the program.

Overall there appears to be little doubt that the problems experienced by the Bureau have contributed to the delay in implementing the health planning program and has delayed the time period required for health systems agencies to achieve full designation and become fully operational.

The health systems agencies included in our review were concerned, as were their predecessor local comprehensive health planning "B" agencies, with the availability and adequacy of data on which to develop a health systems plan. The recent legislation regarding sharing of PSRO data with health systems agencies should help considerably.

Health systems agencies were being hampered in conducting project review because of a lack of final standards or criteria on which to make decisions. HEW's slowness in developing guidelines has delayed the preparation of health systems agencies' plans. In our opinion, national standards and criteria are essential to the orderly development of areawide and State health plans. Such standards should be finalized as soon as possible so that agencies can use them as a basis for developing health systems plans and annual implementation plans.

Concern about the adequacy of salaries and whether the health planning program will be continued has hampered health systems agencies in their ability to attract qualified staff. The job faced by the agencies is at best a difficult one; without adequate staff it may well be an impossible one.

In those States having only one health systems agency there is obvious confusion over the agency's responsibilities as opposed to those of the State health planning agency. This situation exists in 12 States. We see no need for having a State health planning agency and the health systems agency which covers the entire State.

We suggest that the Congress consider expanding the provisions of section 1536 of the act to allow more States to have only a State health planning agency and require that there be a minimum of at least two health systems agencies in all other States.

In passing the National Health Planning and Resources Development Act of 1974 the Congress did not provide health systems agencies with any specific authority over Federal health facilities. Since these facilities are an important part of our national health resources and serve many millions of persons, it is difficult for agencies to disregard them. If the health planning program is to become the vital force that Congress expects it to become and have a major impact on containing costs and improving accessibility to health care, then we believe the institutions created to achieve those objectives must interact with all parts of the health care system. To specifically exclude Federal facilities from the national health planning program, in our opinion, is to seriously impede the ability of the local and State health planning agencies to carry out the responsibilities given them by the Congress.

We believe that Congress should consider amending the act to provide for health systems agency and State health planning agency

reviews of proposed projects involving Federal health facilities and require their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations along with their written responses to any congressional committees before any decisions are made to authorize and/or fund a project.

The extent to which health systems agencies will be successful is largely dependent upon their board members and their attitudes. Recognizing that their task is not an easy one, we were disappointed to see the relatively low level of optimism expressed by health systems agencies' board members in achieving the goals spelled out in the act. In some respects, board members seem to feel they are faced with impossible and sometimes conflicting objectives.

If health systems agencies are to achieve their objectives, they must have the support of local governments, community and professional groups, private health care providers, and various others working in the health care field. As could be expected, this support has been slow in developing and many look upon the health planning agencies with distrust and suspicion. We believe it is vital for agencies to establish their credibility in the health care field as soon as possible. The longer this process takes, the less likely success will be achieved. Consequently, we believe HEW should stress the importance of each health systems agency developing positive relationships with all who are active in the health care field. If fear and mistrust can be successfully overcome, then health systems agencies will have a much greater chance of succeeding.

Mr. Chairman, that is a brief summary of our statement. We will be happy to answer any questions that you and the other members of the subcommittee may have.

[Testimony resumes on p. 142.]

[Mr. Martins' prepared statement follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

STATEMENT OF
JAMES D. MARTIN, DEPUTY DIRECTOR
HUMAN RESOURCES DIVISION
BEFORE THE

SUBCOMMITTE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

ON THE

IMPLEMENTATION OF THE NATIONAL HEALTH PLANNING

AND RESOURCES DEVELOPMENT ACT OF 1974

Mr. Chairman and Members of the Subcommittee, we are pleased to appear here today to discuss some of the problems we have identified in the implementation of the National Health Planning and Resources Development Act of 1974. Our testimony is based on a review of the program that included 15 health systems agencies, 11 State health planning and development agencies, 4 regional centers for health planning, and 4 Department of Health, Education, and Welfare (HEW) regional offices. Our fieldwork was done between November 1976 and June 1977. A draft report on the review is currently with HEW for formal comments.

BACKGROUND

On January 4, 1975, the President signed into law the National Health Planning and Resources Development Act of 1974, Public Law 93-641. The act provides for the development of guidelines for national health planning; the establishment of areawide and State health planning agencies to deal with needed planning for health services, manpower, and faciilties; and financial assistance for the development of resources.

The act builds on the experiences of the Hill-Burton, regional medical, and comprehensive health planning programs and seeks to combine the best features of these programs into a new national health planning and resources development effort.

The act requires that the country be divided into health service areas that are to be appropriate for the effective planning and development of health services. Health systems agencies, also called areawide agencies, are to be designated in each health service area to improve the health status of area residents; increase the accessibility, continuity, and quality of the health services provided; restrain increases in the cost of providing these services; and prevent unnecessary duplication of health resources. Health systems agencies have governing boards whose membership consists of consumers

providers, and government officials. Consumers are to be a majority not exceeding 60 percent of membership.

State health planning and development agencies have overall responsibility for the health planning activities of the State. State-wide health coordinating councils, organizations with a consumer majority and consisting of representataives of health systems agencies in the State and others nominated by the Governor, advise the State planning agency in carrying out its functions.

To assist HEW in carrying out the provisions of the act, the act requires that centers for health planning be established. The purpose of these centers is to provide technical and consulting assistance to health systems agencies and State planning agencies; conduct research, studies, and analyses of health planning and resources development; and develop health planning approaches, methodologies, policies, and standards.

STATUS OF IMPLEMENTATION

Since passage of the act, the country has been divided into 205 health service areas; health systems agencies have been designated in all areas; all State planning agencies have been designated and centers for health planning have been established in each of the 10 HEW regions.

On September 3, 1977, HEW published proposed national guidelines for health planning concerning nine different types

of health services and facilities. As of December 28, 1977, HEW had received more than 55,000 responses--mostly from consumers--to the draft guidelines. Of the over 150 health systems agencies and State health planning agencies that responded, about 20 could be characterized as endorsing the guidelines.

An analysis of responses prepared by an HEW contractor showed that many planning agencies expressed similar overriding concerns such as:

--the guidelines, by imposing nationwide standards, would inhibit local and State initiatives and severely limit planning activities;

--the guidelines were inflexible and arbitrary and especially did not consider the unique needs of rural areas;

--cost containment was the central focus of the guidelines, overshadowing issues such as accessibility to and quality of care; and

--the implementation periods specified in the guidelines were unrealistic because local mechanisms are not in place.

PROBLEMS EXPERIENCED BY HEW IN ADMINISTERING THE PROGRAM

HEW has experienced difficulty in providing its regional offices, health systems agencies, State planning agencies, and State-wide coordinating councils with timely regulations

and guidelines to assist them in implementing the health planning provisions of the act.

As of January 1978, only two of eight sets of regulations needed by local and State health planning agencies have been finalized. Also, as mentioned earlier, the national guidelines for health planning have not been finalized.

Delays have been due primarily to:

--new procedures for finalizing regulations instituted by the former Secretary of HEW. These procedures have been streamlined by the current Secretary.

--organizational problems caused primarily by combining personnel from three former programs to implement the act, and

--an inordinate amount of litigation regarding the act.

As a result, only nine health systems agencies have been able to develop the necessary health systems plans and annual implementation plans required for full designation within the originally prescribed 2-year conditional designation period. Recent amendments to the act (Public Law 95-215) extended the conditional period to 36 months.

In addition, HEW regional offices have had to make policy decisions and augment guidance provided by HEW headquarters, thus creating the possibility that the act or parts thereof are not being implemented consistently throughout the country.

For example, HEW's Denver Regional Office directed the health systems agencies in its region to use an approach that is not consistent with guidelines on health system plan development published by the Health Resources Administration's Bureau of Health Planning and Resources Development in December 1976--almost 2 years after the act's passage.

While the regional approach to plan development is similar to the approach in the Bureau guidelines, it does differ in some significant respects. The Bureau guidelines state that a health systems agency's plans should be based on an assessment of the health status of the population in the health service area whereas the region's approach is for a health systems agency to develop its plans based on an analysis of the health resources in the area. Also, the Bureau guidelines require that the plans cover the entire system of health services and attempt to establish a correlation between the health status of area residents and the results of the health planning activity. In contrast, the region's approach provides for a health systems agency to focus its initial planning efforts on the review

of capital expenditures at the tertiary level of health care--the level that includes highly sophisticated diagnostic and therapeutic procedures such a complex surgical procedures and x-ray, cobalt, and radium therapy. Using this approach, data collection and analysis is limited essentially to obtaining data pertaining to the tertiary level of the health care system.

According to a regional official the philosophy behind the region's approach is that if health systems agencies are successful in putting a "cap" on cost increases associated with tertiary level care, the funds previously flowing to this level will "filter down" to the primary and other levels of the health care system. The official acknowledged, however, that there can be no assurance that such funds would, in fact, find their way to the other levels of the health care system where they may be most needed.

Each of the three other regional offices we visited also found it necessary to augment HEW guidance, but to a lesser extent. One regional official told us that the Bureau at times took 5 to 6 months to respond to policy questions raised by health systems agencies. Because the Bureau was not responsive, regional officials provided verbal guidance based on their experience with other programs. One HEW regional official told us that the act is probably being implemented in a different way in each of HEW's 10 regions because of delays in receiving guidance.

Organizational problems

To implement the act, HEW formed the Bureau of Health Planning and Resources Development by combining the personnel of three programs that were eliminated as a result of the act's passage--the comprehensive health planning, regional medical, and Hill-Burton hospital construction programs. Combining these three programs, each having its own organizational and grade level structures, has resulted in employee morale and dissatisfaction problems, employees functioning without approved job descriptions, and poor communication among the various offices and divisions within the Bureau. These problems in turn have contributed to the delays in developing and publishing regulations and guidelines needed by health systems agencies and State planning agencies to implement the act.

A December 17, 1975, internal report prepared by a task force established by the Administrator of HRA stated that divisions and offices within the Bureau were operating as relatively autonomous units, were not coordinating program operations, and that some persons did not know for whom they were working. The report quoted one manager as having received no delegation of authority and no clear definitions of responsibility either for himself or for his work groups.

The Civil Service Commission identified several personnel management problems during a review of HRA in

January 1976. The Commission's May 1976 report stated that "the primary cause of the HRA's position management problems lies with successive reorganizations in which obsolete positions from abolished functions were absorbed intact and encumbered into the new organization." The report concluded that HEW's reluctance to use reduction-in-force procedures in implementing reorganizations resulted in persons whose functions were abolished one or more reorganizations ago being placed at their same grade levels in other organizations.

The Bureau is currently authorized eight GS-15 positions. As of January 1978, about 3 years since the Bureau was established, 16 GS-15s were employed by the Bureau. In addition, there are 17 Bureau staff members whose job descriptions were not consistent with their duties and who had no specific positions within the Bureau's organization since it was established in March 1975. According to an HEW official, positions could not be found in the Bureau for these persons because they had little or no experience or expertise in health planning.

In September 1977 the Secretary of HEW announced a proposed reorganization of the Public Health Service involving HRA. According to an HRA official, the proposed reorganization will have a limited impact on the management and organization problems being experienced by the Bureau of Health Planning and Resources Development. Also, we were advised

that reduction-in-force procedures will not be used to correct the Bureau's organizational problems. Instead, HEW plans to use its special employee program to find positions for persons whose functions have been abolished.

The development of timely guidelines and regulations has also been affected by 21 law suits filed concerning the act. Only six of these have been settled. Staff normally involved in the regulation development process have been needed to deal with these legal challenges.

PROBLEMS THAT NEED TO BE OVERCOME BEFORE ADEQUATE AREAWIDE AND STATE HEALTH PLANS CAN BE DEVELOPED

The impact of areawide health systems agencies and State health planning and development agencies in restraining increases in health care costs and improving accessibiity to health services cannot be determined because these agencies have been in existence for only a short time. The impact of these agencies in accomplishing these two goals probably will not be known for several years at the earliest.

In order for areawide and State health planning agencies to have an impact on the health care system, meaningful, specific, and thorough areawide and State health plans that are supported by both consumers and providers as well as local governmental entitities will be needed. Without such plans and support, areawide and State health planning agencies will experience serious problems in achieving the goals of the act.

At the time of our fieldwork areawide and State planning agencies were limited in their ability to develop the necessary quality health plans. One reason for this is that limited useful data was available on the existing health care system and status of the health of residents.

All of the 15 health systems agencies we visited were experiencing some degree of difficulty in obtaining the kinds of data necessary to develop their health systems plan. At the time of our fieldwork data sharing relationships between health systems agencies and Professional Standards Review Organizations (PSROs) were uncertain. In some cases needed data were not available, current, or in the necessary form.

Also while most of the health systems agencies we visited had either reached data sharing agreements with PSROs or were in the process of developing agreements, officials of health systems agencies anticipated problems in getting useable data from PSROs primarily because of the data confidentiality provision contained in the PSRO enabling legislation. One health systems agency had already been refused data by the PSRO in its area.

The enactment of Public Law 95-142 should correct problems that health systems agencies might encounter in obtaining data from PSROs. The legislation provides that PSROs shall provide aggregate statistical data (without identifying any individual)

reflecting the volume and frequency of services as a means to assist health planning agencies.

Another problem facing areawide and State planning agencies at the time of our fieldwork was the lack of national standards and criteria for health resources and services. In order for health systems agencies to plan for efficient and effective health delivery systems and to make judgments regarding proposed changes to the system, standards and criteria for the various types of health resources and services are needed.

Several health systems agencies we visited indicated the need for national standards and criteria. One health systems agency official told us that until such standards and criteria were available, they would not engage in a review of proposed health services because such review in the absence of standards and criteria could lead to legal actions challenging the basis of the health systems agency's decision. According to the agency's executive director, legal actions could tie up a considerable amount of the agency's resources.

We obtained statistics from several State planning agencies on the approval rate for applications for new institutional services--new health faciity construction or establishment of a health maintenance organization or any expenditure by an institution in excess of $150,000. The approval rate was about 92 percent. We believe that one reason for

the high approval rate is the lack of standards and criteria on which to evaluate these applications.

The need for timely standards and criteria is particularly important when new technology is developed. For example, concern has recently been expressed about the number of computerized tomography (CT) scanners being acquired throughout the country. CT scanners are relatively new radiological devices that are based on the same principles as conventional x-ray techniques but collect and process information using a computer to transmit three dimensional "pictures" of the body. In the absence of standards and criteria, health systems agencies and State planning agencies have little justification to disapprove a hospital's request to purchase one of these expensive ($400,000-$700,000) machines. As a result, the health care systems could be absorbing unnecessary numbers of scanners with the effect of increased health care costs. The approval rate on applications to purchase scanners in nine States where we were able to develop data averaged 93 percent.

Some health systems agencies have experienced difficulty in employing qualified health planning staff. Limited numbers of persons having experience in health planning are available in certain areas and, in some cases, agencies have been unable to offer salaries that would attract individuals to work for them. Also one health systems agency official indicated that qualified persons were reluctant to work for agencies because

of the uncertainty surrounding the continuance of the health planning program.

Several urban health systems agencies told us that their inability to offer salaries competitive with other health professions had seriously hindered them in employing qualified staff. Salaries for executive directors of the 15 health systems agencies we visited ranged from about $19,300 to $35,000. Salaries of subordinate staff were generally in the $13,0000 to $25,000 range.

Another problem that has impeded the progress of health systems agencies and State health planning agencies is the lack of clarity about their respective responsibilities. This problem was particularly apparent in the States we visited that had only one health systems agency. There are 12 States that have single health systems agencies.

Similar functions of areawide and State health planning agencies include:

--developing health systems plans,

--reviewing applications for new health services, and

--conducting reviews of existing health services to determine their appropriateness.

Officials from both areawide and State planning agencies were concerned over potential conflicts and duplication of effort because of their similar responsibilities. HEW has provided little assistance to statewide health systems agencies and their State planning agencies in dealing with this situation.

A State official in a State having only one health systems agency expressed concern over the power the health systems agency can execute through its representation on the State-wide Health Coordinating Council. The council advises the State planning agency and has final approval of the State health plan. The act requires that at least 60 percent of the membership of a council be made up of representatives of health systems agencies in a State; in the case of a State having only one health systems agency, the agency would have a majority on the council.

Another issue needing resolution deals with the role of the health systems agencies with regard to Federal health facilities. The act is silent on this issue. HEW has interpreted this silence as an expression of congressional intent not to provide health systems agencies with jurisdiction over Federal health care facilities.

Generally health systems agency officials did not consider the exclusion of Federal health facilities from their authority to be one of the major problems confronting them. Several, however, stated that to have a meaningful health planning system, Federal health care facilities should be subject to the same restrictions as other health care facilities. The expansion of Federal health care facilities or the purchase of new sophisticated equipment could have a significant impact on the non-Federal system, particularly where the non-Federal system has been providing services to Federal beneficiaries.

Based on discussions with staff and the results of a questionnaire we mailed to governing board members of the 15 health systems agencies we visited, there was little optimism about the success of the health planning program in improving accessibiity to health care and restraining increases in health care costs. This is particularly noteworthy considering that the health planning program is relatively new and that under such a circumstance more optimism could be expected.

Provider board members were slightly less optimistic than consumers about health systems agencies restraining health care costs and improving accessibiilty to health care.

There are many possible reasons for this apparent lack of board member optimism in accomplishing the goals of the act. One is a perceived lack of health systems agencies authority. Over 66 percent of the questionnaire respondents indicated that agencies had less authority than needed to contain health care costs and almost 65 percent felt similarly about agencies' authority to improve access to health care.

These views were shared by officials at several health systems agencies we visited. Some agencies saw their greatest impact would come from project review activities. They believe that this activity could reduce the construction of unnecessary health facilities and the purchase of unneeded expensive medical equipment. One official, however, described the project review

process as "putting a band-aid on the problem of cost escalation" since health systems agencies have no authority over the activities of private clinics and physicians' offices. Also several agency officials told us that too much authority in the project review process is vested in the State health planning agencies. One health systems agency official told us that the project review functions were often meaningless because the State health planning agency had final approval and that such State decisions were often made without regard to the health systems agency's recommendations. Another agency official said that the greatest benefit his agency can provide at the present time is to educate the public in the availability and use of the health care system and solicit the involvement of the community in health planning through sub-area councils.

Health systems agency officials noted that the act does not provide authority over health manpower distribution or the purchase of expensive medical equipment by physicians, both of which can impact on the cost and accessibility of health care. One official said that agencies should have hospital rate review authority in order to have a positive influence on health care costs.

SUPPORT OF LOCAL GOVERNMENTAL, COMMUNITY AND PROFESSIONAL GROUPS TO HEALTH PLANNING

The involvement of local consumers, providers, and government officials in the health planning system is provided

through their memberships on governing boards. The support of the health planning activities directed by agency governing boards, particularly the approval and support of the health systems plan, by local consumers, health professional groups, and by local governmental entities is needed if health systems agencies are to be successful in achieving the goals of the act.

We asked representatives of consumer organizations, health organizations, and local governments in the health service areas we visited to give us their opinions regarding the success they felt health systems agencies would have in achieving the goals of the act. Generally, the results of these contacts indicate that at the time of our fieldwork agencies had not yet achieved needed credibility in the community and had not gained the confidence and support of the above groups.

Some of the concerns regarding health systems agencies brought to our attention were

--agency staffs in general had no real knowledge of the operation of the health care system.

--agencies seemed to be dedicated to the destruction of the existing health care system.

--agencies were not accountable to the people and thus should not be making decisions that elected officials should be making.

--health providers will dominate and control agencies thus reducing their effectivenes in controlling costs.

--methodologies needed to measure cost, availability, accessibility, and quality of health care have not been developed.

--agencies do not have enough power to contain health care cost and improve accessibility.

--the goals of containing health care costs and improving accessibility to the health care system conflict with one another.

--medical standards and criteria are the responsibility of medicine, not agencies.

--agencies reviewing and commenting on new projects will not be an effective means of containing health care costs.

---savings attributable to preventing the construction of unnecessary health care facilities or the acquisition of unneeded equipment may be offset by the costs associated with preventing such expenditures.

A number of groups we talked to had not yet formulated opinions and were waiting to see what happens in the next year or two. They acknowledged that health systems agencies will experience difficulties in having an impact on the health care system without the support of the consumer, provider, and local governmental entities.

EFFECTIVENESS OF REGIONAL CENTERS FOR HEALTH PLANNING

The act requires HEW to establish regional centers for health planning to assist it in providing technical and consulting assistance to health systems agencies, State health planning agencies, and State-wide Coordinating Councils. The four regional centers for health planning agencies we visited had made limited progress in assisting health planning agencies because of (1) difficulties in identifying technical assistance needs of planning agencies, (2) delays in issuance of HEW regulations, (3) lack of receptiveness of planning agencies to center assistance, and (4) inappropriate requests for assistance.

The amount of assistance provided health systems agencies varied among the four regional centers for health planning we visited. Each, however, was behind schedule. One center had visited only 3 of the 16 total health systems agencies and State health planning agencies in its region and had provided very limited assistance. The other three centers were somewhat more active.

Officials at one center cited the HEW delays in providing guidelines as a reason for lack of assistance to areawide and State agencies. A center official noted that centers are not policy-making organizations and thus cannot develop needed criteria and guidelines.

One of the functions of the regional centers for health planning is the training of health systems agencies' board members. The governing board makes decisions regarding new project applications and is generally responsible for the activities of the agency. It would appear that consumer board members particularly need assistance in understanding the health care system, the act, the functions and responsibiities of health systems agencies, and the relationship between areawide and State agencies, coordinating councils, and other planning organizations in the health service area.

Our questionnaire to agency governing board members indicated that many consumer board members lacked knowledge regarding the health care system. Over 30 percent of the questionnaire respondents indicated consumers had little or no such kowledge. If consumers are to be able to participate on an equal basis with more knowledgeable providers, training and education programs need to be provided.

The regional centers for health planning have not been successful meeting this need although each of the four centers we visited had conducted some governing board training sessions. Again our questionnaire provided some insight into the success of the centers in assisting agency governing board members. While 25 percent of the respondents rated their experiences with the regional centers for health planning as being good or very good, 44 percent indicated they had no contact with the centers.

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Officials and staff at many of the health systems agencies and State health planning agencies we visited were not enthusiastic about the assistance received so far from regional planning centers. A group of health systems agencies in one region had advised the planning center that their assistance had not been responsive to their requests. Several health systems agencies expressed the opinion that the regional planning center staff was not more qualified or knowledgeable in the health planning field than their agency staff.

Some health systems agencies, however, thought the concept of having regional planning centers was good and that they offered a good potential source of assistance.

SUMMARY

In summary, Mr. Chairman, the organizational structures, health systems agencies, State health planning agencies, Statewide coordinating councils, and regional centers for health planning are in place and operating throughout the country. A number of problems, however, need to be overcome before these organizations will have a significant impact on the rising cost of health care and the need for improved accessibility to quality care.

HRA's Bureau of Health Planning and Resources Development must act to finalize regulations and provide adequate guidance to the HEW regional offices as quickly as possible. Delays in providing instructions to the regions resulted in decisions being made regarding the implementation of the health planning

act which appear to be inconsistent with initial Bureau guidelines. Moreover, these delays also may have caused inconsistent implementation of the planning program throughout the country.

The organizational problems experienced by the Bureau need to be remedied as soon as possible to insure the orderly implementation of the health planning program.

The large amount of litigation regarding the act has tied up Bureau personnel and resources and has been responsible for some of the delay in implementing the health planning program. Resolution of the various legal challenges to the act and the way it is being implemented could have a significant impact on the program.

Overall, there appears to be little doubt that the problems experienced by the Bureau have contributed to the delay in implementing the health planning program and has delayed the time period required for health systems agencies to achieve full designation and become fully operational.

The health systems agencies included in our review were concerned, as were their predecessor local comprehensive health planning "B" agencies, with the availability and adequacy of data on which to develop a health systems plan. The recent legislation regarding sharing of PSRO data with health systems agencies should help considerably.

Health systems agencies were being hampered in conducting project review because of a lack of final standards or criteria on which to make decisions. HEW's slowness in developing guidelines has delayed the preparation of health systems agencies' plans. In our opinion, national standards and criteria are essential to the orderly development of areawide and State health plans. Such standards should be finalized as soon as possible so that agencies can use them as a basis for developing health systems plans and annual implementation plans.

Concern about the adequacy of salaries and whether the health planning program will be continued has hampered health systems agencies in their ability to attract qualified staff. The job faced by the agencies is at best a difficult one; without adequate staff it may well be an impossible one.

In those States having only one health systems agency there is obvious confusion over the agency's responsibilities as opposed to those of the State health planning agency. This situation exists in 12 States. We see no need for having a State health planning agency and and health systems agency which covers the entire State.

We suggest that the Congress consider expanding the provisions of section 1536 of the act to allow more States to have only a State health planning agency and require that

there be a minimum of at least two health systems agencies in all other States.

In passing the National Health Planning and Resources Development Act of 1974 the Congres did not provide health systems agencies with any specific authority over Federal health facilities. Since these facilities are an important part of our national health resources and serve many millions of persons, it is difficult for agencies to disregard them. If the health planning program is to become the vital force that Congress expects it to become and have a major impact on containing costs and improving accessibility to health care, then we believe the institutions created to achieve those objectives must interact with all parts of the health care system. To specifically exclude Federal facilities from the national health planning program, in our opinion, is to seriously impede the ability of the local and State health planning agencies to carry out the responsibiilties given them by the Congress.

We believe that Congress should consider amending the act to provide for health systems agency and State health planning agency reviews of proposed projects involving Federal health facilities and require their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations along with their

written responses to any congressional committees before any decisions are made to authorize and/or fund a project.

The extent to which health systems agencies will be successful is largely dependent upon their board members and their attitudes. Recognizing that their task is not an easy one, we were disappointed to see the relatively low level of optimism expressed by health systems agencies' board members in achieving the goals spelled out in the act. In some respects, board members seem to feel they are faced with impossible and sometimes conflicting objectives.

If health systems agencies are to achieve their objectives, they must have the support of local governments, community and professional groups, private health care providers and various others working in the health care field. As could be expected, this support has been slow in developing and many look upon the health planning agencies with distrust and suspicion. We believe it is vital for agencies to establish their credibility in the health care field as soon as possible. The longer this process takes, the less likely success will be achieved. Consequently, we believe HEW should stress the importance of each health systems agency developing positive relationships with all who are active in the health care field.

If fear and mistrust can be successfully overcome, then health systems agencies will have a much greater chance of succeeding.

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Mr. Chairman, this concludes our statement. We shall be happy to answer any questions you or other Members of the Subcommitte may have.

Mr. ROGERS. Thank you very much, Mr. Martin, for your helpful statement.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. Martin, how do you think this legislation is working at the present time? On a grade basis of A, B, C, and D, A meaning excellent, how would you grade this system, after your investigation?

Mr. MARTIN. Well, at this point I think it is a little too early to tell how it will work.

Mr. CARTER. Not will but are. The 16 agencies that are in effect now, how are they doing?

Mr. MARTIN. At this particular point in time they have accomplished very little. They have been in an organizational mode without the national guidelines and the regulations that HEW needs to develop and finalize. They have not had a good opportunity to really show how well they can work.

Mr. CARTER. You have visited HSA's I take it.

Mr. MARTIN. Yes, our staff has.

Mr. CARTER. How did you find them functioning? How were they functioning? Were they working well, HSA's, health systems agencies?

Mr. FENSTERMAKER. At the time of our review, Dr. Carter, many of the agencies were searching for guidelines with which to make decisions on projects. They were waiting for the standards. I know at least one agency that we visited and talked to, that refused to do any project review until guidelines were provided. The concern was that they would spend a lot of time in litigation as a result of making decisions without these guidelines. They were concerned about being forced to make decisions really on their own.

Mr. CARTER. The HSA's had not made that many decisions?

Mr. FENSTERMAKER. We did look at the number of projects that were reviewed by the agencies and we found the approval rate was running around 92 percent of all the projects they looked at.

Mr. CARTER. Ninety-two percent. Was that consistent throughout our country? Would that have stayed within the proposed $2.5 billion cap?

Mr. FENSTERMAKER. It would be difficult to answer that but certainly doubtful.

Mr. CARTER. The answer would be no, I would think, right off the bat.

I believe that is it. You visited some health planning centers, is that correct?

Mr. FENSTERMAKER. Yes, sir.

Mr. CARTER. How did you find them to be working?

Mr. FENSTERMAKER. The regional centers for health planning were having difficulty, No. 1, determining what it was that the individual health systems agencies were looking for and there seemed to be somewhat of a disagreement between the centers and the HSA's as to what the proper role of the centers was. In some cases the HSA's were looking for guidance as to how their staff should function and as to the level of education of their staff. I think the centers, how-

ever, perceived their function somewhat differently; they wanted to get into the actual health planning process.

Mr. CARTER. Actually the center's function is for research and planning, is it not?

Mr. FENSTERMAKER. And technical assistance.

Mr. CARTER. It is a research sort of thing. What about the State health planning and development agencies, how are they doing? That is a different group, of course.

Mr. FENSTERMAKER. I think the biggest problem we found there, Dr. Carter, was where there was one health systems agency in the State. In these particular cases there was confusion over the role of the State and local agencies. This situation exists in 12 States.

Mr. CARTER. Of course we have three. We have HSA's and SHCC's and the State health planning agencies. SHPDA, SHCC and HSA's. Were they coordinated? Were they working together?

Mr. FENSTERMAKER. Again it was very early in the review. We did see some instances where the HSA's were somewhat frustrated because their decisions were being overturned by the State agencies.

Mr. CARTER. By the State agencies. Which State agencies; the State coordinating agency?

Mr. FENSTERMAKER. No, the SHPDA. I should not say overturned. The State has the ultimate responsibility for project approval. Some States were not going along with the suggestions of the HSA's.

Mr. CARTER. By the local people, in other words?

Mr. FENSTERMAKER. Yes.

Mr. CARTER. Do you think we should strengthen the State's role in this legislation, or is it strong enough already?

Mr. FENSTERMAKER. I think the intent behind it was to place the planning functions at the lowest level which would be——

Mr. CARTER. At the local level?

Mr. FENSTERMAKER. Yes.

Mr. CARTER. And you really think perhaps that the SHPDA's have really constrained the HSA's, is that correct?

Mr. FENSTERMAKER. There were some indications of it.

Mr. CARTER. Yes, sir. Would you advise us to enact legislation so that the Governor would have a veto power over certificates-of-need?

Mr. FENSTERMAKER. I think that could be construed as somewhat inconsistent with the original intent behind the legislation.

Mr. CARTER. Construed as what?

Mr. FENSTERMAKER. Somewhat inconsistent with the original intent of the legislation.

Mr. CARTER. Thank you very kindly, sir.

Mr. ROGERS. Mr. Florio.

Mr. FLORIO. Thank you, Mr. Chairman.

One of the points you made was your feeling that the HSA's should have jurisdiction over Federal facilities in the health care field. I assume the rationale for this is to avoid duplication or to maintain some control over the budgetary process for expenditure on these Federal facilities. Don't you regard the Federal effort in passing the budget and the whole Federal budget review process as being satisfactory?

Mr. MARTIN. What we have in the report and what our statement is intended to convey is that the HSA should have an opportunity to comment on the Federal facilities and provide them to the Federal agency.

Mr. FLORIO. Which Federal agency?

Mr. MARTIN. Well, if the Department of Defense is putting a new hospital in an area that an HSA has responsibility for, we feel it should have opportunity to review what is going to be the project in terms of beds, types of services to be provided, and provide its comments to the Department of Defense. We then have recommended that the Department of Defense be required to submit those comments together with their analysis to the appropriate congressional committees and allow the Congress to have that information available when they are making budget decisions. In other words, we are not asking that the decision be taken away from the Congress, only that information provided by the HSA be provided to the Congress for their consideration.

Mr. FLORIO. My only observation is that the HSA's have the authority to review and comment on anything they want. I gave an example this morning of things they review that I don't think is appropriate, but the fact is they have the authority right now. Likewise, we would hope that the Federal agencies, the Department of Defense or anyone else, would have appropriate comments in testifying before both the authorizing and the appropriating committees with which they are involved. I can see an opportunity for some mischief and really fully appreciate the corresponding good that is to be achieved by congressional review.

Mr. MARTIN. I think the difference in what we are recommending and what is happening now is that there would be a requirement that the Federal agency provide to the Congress the HSA's comments. As I understand it, that is not now a requirement. The HSA can comment. The comments go to the Federal agency. The Federal agency can do whatever they want after they receive those comments, they do not have to provide them to the Congress. We are asking that that one step be added.

Mr. FLORIO. Does your Division have jurisdiction over a GAO report that is to be released next week concerning VA evaluations and valuation of VA hospital proposals?

Mr. MARTIN. Yes, sir.

Mr. FLORIO. Are you familiar with the terms of the report?

Mr. MARTIN. We have done several reports on VA hospitals. I am not sure the specific one you are referring to.

Mr. FLORIO. Specifically the one requested by Senator Proxmire to look into the feasibility of new construction. I believe that is the general thrust of what is in the report.

Mr. MARTIN. Yes, sir, and there are several hospitals we have looked at.

Mr. FLORIO. You don't have a comprehensive report on each hospital, you have eight reports?

Mr. MARTIN. No; we issued a report on three and we are now looking at five and we will issue a report on the remaining five when the review is completed.

Mr. Florio. I am specifically interested in the Camden VA hospital which the administration and OMB have requested be eliminated. Part of the news in today's paper says that the GAO recommendation to eliminate that hospital is based on a computer-based need of hospital beds. Can you tell me what this means?

Mr. Martin. Yes, sir, I can try. I am not involved in the details of that but I will try to give you a general explanation. Our initial work in this area was done in connection with the Department of Defense job that we did in San Diego. We devolepd a model using data from community hospitals which included information on the diagnosis and the age of patients. We then took the number of patients that were involved in that San Diego military hospital, analyzed them against the data we had from the civilian community and then projected, if the length of stay was reduced to be the same as that in the community, how many beds would be required to serve that population. We have taken the same model that we have developed for the Department of Defense hospitals, modified it and applied it in the VA system.

Mr. Florio. This is not the appropriate place to go into the obvious difficulties with using a military hospital in comparison with a civilian hospital, but the need is obvious for different evaluations as to length of stay, and so on, for the differences between a military hospital, a civilian hospital, and a veterans hospital. There is a lot of difficulty that goes with trying to make such comparisons.

Mr. Martin. We are aware of that. The one thing this model does, it predicts the number of acute beds that are needed which is kind of a key thing when you are talking about cost of medical care—how long does a patient stay in a bed. Can they be housed in a less expensive facility quicker. We tried to show that it is possible to get patients out of acute beds into some other less expensive type of facility which results in less cost and a reduced need to construct highly sophisticated acute care beds.

Mr. Florio. And that is the major thrust we are using for this model in terms of duration of bed stay?

Mr. Martin. Length of stay which takes into account the availability of beds.

Mr. Florio. If someone does not have to stay in a bed as long, would that make many more beds available?

Mr. Martin. It makes those beds available quicker. You can turn patients over quicker, yes, sir.

Mr. Florio. I would just conclude by making the observation that we have a somewhat unique feature in the VA hospital system. That is, we have a higher need for long-term care facilities because the veteran population is aging much more substantially than the general population. Therefore, if there are not adequate long-term care beds, veterans may have to stay in short-term care beds. I accept what you are driving at. However, it seems somewhat inequitable to say that because the Government has not done what it should do in providing long-term care beds, and therefore, because of that deficiency, we are not going to let the veteran have the hospital for the sole purpose of avoiding putting him in the acute care facility.

Mr. MARTIN. We are not saying that in Camden. We don't think there is a need because of the accessibility of the Philadelphia veterans hospital. However, in those hospitals we have looked at we have not said that there should not be adequate long-term care type facilities. That is exactly the point we are trying to make, do not build acute-care beds if you need long-term time. Build the type bed to take care of the patient population you are dealing with.

Mr. FLORIO. Let me conclude by saying that I read in the newspaper that the results of your report are not due to be released until next week. I would appreciate receiving a copy of the report when it is released.

Mr. MARTIN. Yes, sir.

One of the things in connection with the Camden hospital—and I am not sure where the information is coming from you are reading—we have not released that report yet. We are suggesting that the VA would add 120 long-term care beds at Philadelphia to take care of some of that population you are concerned about.

Mr. FLORIO. I will save the arguments for a better forum.

Mr. ROGERS. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

I unfortunately have to go to another meeting but I did want to ask a few questions of Mr. Martin.

The proposed amendments make it more difficult for the persons outside of an HSA to receive personnel files. If you were charged with investigating the hiring practices within one HSA, would this limit an adequate investigation?

Mr. MARTIN. We do not think so.

Mr. WAXMAN. You do not?

Mr. MARTIN. No, sir.

Mr. WAXMAN. You do not have subpena powers, isn't that correct?

Mr. MARTIN. Not under this program, no, sir.

Mr. WAXMAN. Nevertheless, you would feel that you could conduct an investigation?

Mr. MARTIN. Yes, sir. We have had only a limited opportunity to analyze the provision but we have talked with our General Counsel, personnel, and we would have access to records.

Mr. WAXMAN. Do you feel HEW has provided good oversight of HSA elections and operations?

Mr. MARTIN. I would like Mr. Gerkens to comment on that.

Mr. GERKENS. Again we feel HEW is not necessarily at fault. I think in the specific case you are referring to, definitely it was not the case.

Mr. WAXMAN. Well, do you agree there is a potential in health planning programs for improper use of government funds, and can you suggest an oversight mechanism which will prevent this from happening? I am not referring to any one specific region but whether this is a problem throughout the country.

Mr. GERKENS. I think there is definitely a need for greater oversight and evaluation of HSA's by HEW across the board. We found that generally the staffs at the regional level were not adequate to deal with the number of HSA's, SHPDA's, and SHCC's they have under their authority.

Mr. WAXMAN. You said you looked at four regions.

Mr. GERKENS. That is correct.

Mr. WAXMAN. Did you find that HEW was inadequate in all four of the regions?

Mr. GERKENS. Yes; they were. They had a tremendous workload and found it very difficult to deal with that workload.

Mr. WAXMAN. Is that due to lack of personnel to carry out the oversight functions?

Mr. GERKENS. Yes; generally the number of personnel was lacking. We were impressed with the caliber of the people at the regional level, but they didn't have the number of people they really needed

Mr. WAXMAN. Were you impressed with the caliber of people in all four regions?

Mr. GERKENS. I would say so, yes.

Mr. FLORIO. It is my understanding that HEW in the recent past—I know in 1976—engaged in a massive job audit program, particularly in public health service, which resulted in the downgrading of a substantial number of people who are involved in monitoring the HSA's and the whole health planning program. I know that they were doing this in the Philadelphia area, they were doing it in Atlanta, Georgia; Seattle, and San Francisco. Have you had any occasion to look into this whole process and its impact on the HSA to determine the capability of the Public Health Service and the appropriate health officials to oversee the health planning law?

Mr. GERKENS. That did come up in a couple of regions we did visit and it was cited as a problem in maintaining the necessary people on board to do so, but we did not look at that program specifically, no.

Mr. FLORIO. Do you know if this downgrading program is a continuing thing? Since the change of administration, has there been any change in it?

Mr. GERKENS. I don't know. I could not answer that.
to do the job.

Mr. FLORIO. I have no further questions.

Mr. ROGERS. How many of the health systems agencies were fully designated that you inspected?

Mr. MARTIN. There were nine in total. Are you asking about the number that we looked at?

Mr. ROGERS. Well, I think you looked at 15.

Mr. MARTIN. We looked at 15 and none of those as I understand it have been fully designated.

Mr. ROGERS. None of the 15 you looked at?

Mr. MARTIN. None of the 15. There have been 9 in total though of the 205.

Mr. ROGERS. I think now HEW has nine fully designated.

Mr. MARTIN. Yes.

Mr. ROGERS. By next September they hope to have 175.

Now I presume that in looking at these, even though they are not fully designated, you were able to see some of the problems they have been having. How would you sum it up, setting forth for us what you see as the most significant organizational problems and then the funding problems, if any?

Mr. MARTIN. In terms of the major problems I think a lot of their problems go back, as we have indicated earlier, to the need to have the national guidelines out in final form and the regulations in final form so that they will have them to use when they go through their planning process. I think there are a number of them that have problems in bringing aboard competent quality staff to do the planning.

Mr. ROGERS. For staff?

Mr. MARTIN. Yes, sir, staff. To get quality staff to do the type of planning that needs to be done.

Mr. ROGERS. Is it lack of money or just a lack of people?

Mr. MARTIN. I think some of the concern is people and some of the concern is also in the salaries they are able to pay. At least there was some indication, that they were not able to pay sufficient salary to attract quality people. Some of it goes back to not having enough of the type people they need to be able to hire.

There is also a lack of data that they need in terms of the facilities that are in the HSA service area, the types of services that are offered by those facilities, also the number of providers in the area and also where people are actually getting their care. Where do they go for care? They may reside in the HSA but they may go outside of HSA. That type of data must be available for them to do their planning. I don't know whether Mr. Fenstermaker or Mr. Gerkens would like to add to that but I think those are basically the problemse we found with the HSA's in general.

Mr. FENSTERMAKER. I would like to add, Mr. Chairman, that a number of the HSA's we visited indicated to us their concern about the issues of cost containment versus accessibility of care and many of them perceived this as being a conflict. They did not see how they could be working toward cost containment and at the same time be attempting to increase the quality and the availability of care in a given area.

We have considered this and in our draft report have taken the position that generally this is not necessarily inconsistent. We feel that there are probably a number of health systems areas in which there is a general availability of care or probably more care than is necessary and at the same time there are probably large geographical areas in which insufficient care is available. We think in these situations the health systems agency can be working to redirect available resources and improve any geographic imbalances in health care availability that exist, so we don't necessarily believe that it is inconsistent.

Mr. ROGERS. All right.

Mr. FLORIO. Just two points. One is an inquiry. In terms of the operations of HSA, the whole philosophic base of the HSA is great reliance upon the consumer representation. I have found in looking at some HSA's that the staff does a very good job in terms of in-house educational programs to augment the consumers' degree of knowledge so that they better understand what is going on, understand the jargon and can be even better participants in the process. Other HSA's have not done this so well, it seems.

Have you found varying degrees of consumer education programs or, have you found some HSA's where there is no education program

in existence for purposes of educating the consumers as to basic medical knowledge?

Mr. MARTIN. There is a variance between the type of training that has been provided.

Mr. FLORIO. As the people who are dealing with this legislation would we be well advised to consider writing into the law the need for programs of this type, on-the-job training programs and that sort of thing?

Mr. MARTIN. It may be appropriate to provide in the legislation more specifics as to what the health centers are to provide in terms of assistance and technical training to the staffs and the board members, yes, sir.

Mr. FLORIO. I would like to comment on the other point you made, sir, about the alleged conflict boetween cost containment and quality health care. One thing has to be realized, both terms are relative. Obviously, we can contain costs by eliminating all of the money. However, that is not very realistic. Nor can we maximize quality of care by having everything for everybody in every hospital. That is not feasible. We have to be candid enough to say that we are not shooting for maximum quantity. We are shooting for maximum quality and, that will require a huge education job, not only to the HSA members, but to the general public as well. All too frequently what happens is that some group with an interest comes in and says, for example, "we want to make sure that we have the facilities for delivery of births in every hospital." The fact of the matter is, we cannot satisfy the desires of every interest group.

An awful lot has to be done to convince people that they will not really be adversely affected by not having the most up-to-date facilities at their fingertips. We will have to do something about building into the HSA this mentality of tradeoffs, because we are not going to have everything we want at minimum cost.

Thank you, sir.

Mr. FENSTERMAKER. One comment, Mr. Florio, on the role of the centers. We did send a questionnaire to all the members of the boards of the HSA's that we visited and asked them to what extent were they satisfied with the services being provided by the centers. I think the most startling statistic that came out of this effort was that 44 percent indicated they had never had any contact with the centers for health planning.

Mr. ROGERS. The 15 agencies that you inspected, how long had they been in existence?

Mr. GERKENS. They were relatively new. We did our review between November 1976 and June 1977 and most of the HSA's had been designated in July or October of 1976. Some of them, of course, were former CHP agencies and had some experience in health planning and they obviously were further along than some of the others.

Mr. ROGERS. We asked you to look at them at a time when they were just beginning.

Mr. GERKENS. That is correct.

Mr. ROGERS. So I imagine a lot of them had not had much contact with anybody, had they?

Mr. GERKENS. That may be true. we were trying to get a feel as to the board members overall impressions regarding the overall act.

Mr. ROGERS. I think your study was done by the General Accounting Office a little early before we really had much experience with the HSA's. It is not easy to make judgments although I think what you pointed out certainly will be helpful to us.

Mr. MARTIN. Yes. Despite the fact that it was early, I think we identified some problems early that HEW needs to be aware of and needs to work on now.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

What about our SHCC's, our State health coordinating councils? Are they being financed pretty well?

Mr. GERKENS. Dr. Carter, we really didn't address that during our review and it was relatively new.

Mr. CARTER. You didn't address it?

Mr. GERKENS. That is correct.

Mr. CARTER. What about the progress of the statewide health coordinating councils in fulfilling their duties?

Mr. GERKENS. They were just getting started at the time of our review and we really didn't take a look at the SHCC's.

Mr. CARTER. Do you know whether they have much staff or not?

Mr. GERKENS. I guess that depends on the State, whether the State is willing to give the SHCC's staff.

Mr. CARTER. I wonder about the State of Illinois. They are supposed to coordinate the SHA's.

Mr. GERKENS. I could not address that.

Mr. ROGERS. What about it, Miss Berger? Do you have much of a staff?

Miss BERGER.[1] At the SHCC?

Mr. ROGERS. Yes. Do you have an adequate staff?

Miss BERGER. We have a new executive secretary of the SHCC.

Mr. CARTER. Do you have enough trained people to assist you?

Miss BERGER. I don't think that we can tell at this point.

Mr. CARTER. Thank you very kindly.

Miss BERGER. Thank you.

Mr. CARTER. You visited 10 regions I believe you stated.

Mr. GERKENS. Four regional offices.

Mr. CARTER. I believe I read that there are 10 planning regions.

Mr. GERKENS. That is right. Ten HEW regional offices and 10 regional centers for planning across the country.

Mr. CARTER. And they have been operating in 10 different directions, according to your testimony.

Mr. GERKENS. Dr. Carter, that was a speculation of some people at the regional level because of the lack of guidance.

Mr. CARTER. Does that mean you have written down something to that effect, that there was no coordination? Is that not correct?

Mr. GERKINS. Yes.

Mr. CARTER. All right. You mentioned that there was more of an emphasis on cost containment than there was on service to the people, is that correct?

Mr. MARTIN. There was confusion about the relative emphasis to be placed on both.

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[1] Miss Sally Berger, Chairman, National Council on Health Planning and Development, was in the audience.

Mr. CARTER. All right. HEW, the organization, appoints the regional office director or the regional health planning director. How will this then affect the planning process? What would it mean to the influence of Governors especially if the regional directors were given approval of health plans, certificates of need and so on? Do you think that would be wise to let the regional directors——

Mr. MARTIN. Are you referring to the HEW regional directors?

Mr. CARTER. Yes.

Mr. MARTIN. No, I don't think the regional directors of HEW should have approval or disapproval authority of the situation. I think that should be left up to the local HSA's and the States to administer.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much. We are grateful to you, Mr. Martin, and your colleagues for being here and giving the benefit of your study.

Mr. MARTIN. Thank you.

Mr. ROGERS. The next witness will be Mr. Albert H. Rohling, executive director, Birmingham Regional Health Systems Agency, Inc., and president, Southeastern Association of Health Systems Agency Executives.

We welcome you, Mr. Rohling.

STATEMENT OF ALBERT H. ROHLING, EXECUTIVE DIRECTOR, BIRMINGHAM REGIONAL HEALTH SYSTEMS AGENCY, INC., AND PRESIDENT, SOUTHEASTERN ASSOCIATION OF HEALTH SYSTEMS AGENCY EXECUTIVES, ACCOMPANIED BY TONY GOETZ, EXECUTIVE DIRECTOR, EAST KENTUCKY HEALTH SYSTEMS AGENCY; AND DON TRANTOW, EXECUTIVE DIRECTOR, CENTRAL GEORGIA HEALTH SYSTEMS AGENCY

Mr. ROHLING. Thank you, Mr. Chairman.

Our Southeastern Association is composed of 41 health systems agency directors in the eight Southeastern States of North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, and Mississippi and it is my pleasure to appear before you to speak for our Association and its members.

Although the National Health Planning and Resources Development Act received the Presidential signature in January 1975, after thorough congressional discussion in the 93d Congress, the lengthy process of initial implementation has only recently been completed. At the heart of the implementation of the law is the health systems agency, the local decisionmaking body, whose governing structure is broadly representative of the local community which it serves. The first health systems agency was designated in April 1976. Now the country has full coverage through the 205 HSA's. As indicated earlier, 41 of these agencies are located in the eight Southeastern States.

Our Southeastern HSA's are presenting to each of you and to your fellow legislators a document which we have released today entitled: "Progress Through Participation: Health Planning in the Southeast." [See p. 154.]

The document reveals significant accomplishments in both health planning and resource development during the first 18 months of HSA operation, a period which ended on December 31, 1977. This is certainly a short period of time from which to present intended accomplishments; nevertheless, it is possible to present some conclusive statements. "Progress Through Participation: Health Planning in the Southeast" gives testimony to the fact that the National Health Planning and Resources Development Act is fundamentally well designed and has been capable of achieving initial desired results in its earlies stages.

The information being released today in this document will focus on: (1) The willingness and appropriateness of local citizens, properly formed in an HSA governing body structure as prescribed in the current statute, to maintain their established role as health decisionmakers; (2) their ability to represent the public, be accountable to the public and serve in the public interest; and (3) their ability to have a major impact on health costs while insuring the proper mix of health services in their areas.

Local citizen planners in all but 3 of the 41 Southeastern health service areas have already established health systems plans and prepared their agencies to move into full designation status.

A major achievement was the development, at the local level, of dedicated groups of consumers, providers of health care, and public elected officials who have worked diligently to implement the National Health Planning and Resources Development Act. An essential resource in the national health planning effort, these citizen groups who govern the HSA's form the necessary network of a broadly representative planning capability for community decisionmaking.

In the Southeast, 2,500 residents—55.5 percent of them consumers—have devoted more than 100,000 unpaid hours serving on HSA governing bodies since the agencies became operational in the summer of 1976. With the additional participation of thousands of other citizens serving on subarea councils, task forces, and various committees, southeastern residents compiled an 18 month record which is characterized by the following examples:

$2.5 billion worth of proposed health spending was reviewed and evaluated by residents serving on HSA governing bodies and they recommended disapproval of 235 proposals for spending slightly more than $367 million as part of their responsibilities in limiting duplicative, inappropriate and unnecessary health spending. These figures do not take into account an undetermined but equally substantial sum of money which has been saved through reductions and reallocations negotiated between applicants of proposed expenditures and the Health Systems Agency. Nor does it take into account the fact that our very presence as a local reviewing body discourages much undesirable spending.

In addition to HSA governing body members, more than 21,000 other citizens demonstrated their interest by attending 871 public hearings sponsored by the agencies in conjunction with proposed spending reviews and consideration of health systems plans.

Combined, southeastern HSA governing bodies, executive committees and subarea advisory councils averaged almost a thousand meetings each month with each meeting publicized and open to the public.

The entire concept of local decisionmaking in health, a value which "Progress Through Participation: * * *" shows to be truly alive in our democratic society, has been enhanced by the January 18th statement of HEW Secretary Califano which accompanied the most recent draft of the "National Health Planning Guidelines." The Secretary acknowledged that HEW's role is not to make decisions but to establish broad national standards to provide general guidance to local agencies. He stated that "those agencies in turn must take HEW's standards and adapt them to special local needs and conditions." In this context, HSA's can make even more substantial progress in their cost containment efforts.

Finally, as "Progress Through Participation: * * *" has shown, local decisionmaking is most cost containment conscious. However, southeastern residents are overwhelmingly in favor of improved positive resource development. Our HSA directors report a feeling of disappointment in their constituencies that the national budget has not provided appropriations to activate the Area Health Service Development Fund. The HSA's will not have sufficient means to bring about the implementation of our locally developed goals and objectives until that Fund is activated.

Mr. Chairman, I would like to add two points that are not in my prepared statement that have to do precisely with two elements in the current bill under your consideration. The first concerns the selection process or the question, who will elect governing body members on HSA boards and who will appoint committee and task force members?

In almost every case in the Southeast the governing bodies have exercised this responsibility and we think our testimony today demonstrates the effectiveness of that role and of that model of developing the selection process. We are aware that in some cases some abuses have occurred in this arena but to legislate for all to compensate for the abuses of a few may not be the best course. The courts have also decreed that HEW has the role of monitoring abuses in this regard and we would hope that they could assume that role with greater vigor.

The other point I would like to make is the proposed 1 year extension of the legislation. Our agencies feel that is inadequate if this is to become a stable program in our communities. The confidence on the part of the Congress must be expressed in a minimum of a 3-year extension; otherwise, the stability of the program is questionable: You heard earlier the report from the GAO which talked about the ability of the agencies to recruit and employ qualified staff. Certainly, only a 1 year extension creates even greater problems along those lines.

My two associates and myself will be pleased to respond to your questions.

[Testimony resumes on p. 178.]

[The document referred to follows:]

PROGRESS THROUGH PARTICIPATION

Health Planning In The Southeast

This summary report on Progress through Participation *presents information compiled by the 41 Health Systems Agencies serving the eight Southeastern states.*

As are all records and data of Health Systems Agencies, this information is available for public inspection and copying. Further details about any of the 41 HSAs may be requested directly from the Executive Director of the HSA, whose name and address is among those listed at the end of this report.

Authorship of this report might well be attributed to the many thousands of concerned consumers and health care providers whose dedicated commitment of time and effort is responsible for the progress and participation presented on these pages.

January 30, 1978

Southeastern Association of Health Systems Agency Executives

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SUMMARY

During the first year and a half of their designation as agencies responsible for effective health planning in the 41 Southeastern health service areas, Health Systems Agencies have recorded notable progress. Consumers and providers of health care joined together in a spirit of cooperation to form nonprofit corporations, prepare designation applications, select representative governing bodies, recruit skilled professional staff, and participate in health planning and resources development decisions at the local level.

Surmounting a series of continuing challenges, HSAs developed and adopted detailed health plans outlining solutions to locally identified health problems and needs. Operating with funding levels less than those authorized by the National Health Planning and Resources Development Act -- and moving ahead using locally developed policies and procedures based on the Act, because of long delays in the publication of national regulations -- HSAs recorded a significant investment of community effort. A total of 2,509 residents served on HSA governing bodies, devoting 105,000 hours of unpaid personal and professional time to the success of these important endeavors.

Residents not serving on HSA governing bodies also demonstrated their commitment in large numbers, with 2,600 persons serving on subarea advisory councils and 4,000 participating as members of various committees, task forces, technical assistance groups, and other such local advisory and informational groups.

While handling the many details of launching newly formed locally controlled corporate entities to undertake the many and varied functions responsive to the complex requirements of the National Health Planning and Resources Development Act, the HSAs performed a key role in assisting to restrain rising costs through their review activities. Almost two and a half *billion* dollars worth of applications and projects for proposed capital expenditures by health care facilities and/or proposed spending of federal health dollars were reviewed.

Discharging their responsibility to participate in limiting duplicative, inappropriate, and unnecessary spending, local residents serving as HSA governing body members recommended disapproval of 235 proposals for spending slightly more than $367,000,000.

Savings in proposed expenditures recommended for disapproval by the HSAs during this part of the conditional designation period are more than ten times the amount of Area Health Services Development Funds authorized by the National Health Planning and Resources Development Act for Southeastern HSAs to spend in assisting in the planning and development of projects and programs necessary for the achievement of health system improvements outlined in their local health plans. These activities would include working toward increasing the accessibility, acceptability, continuity, and quality of health services. So far, no monies have been appropriated with which to support the authorized Area Health Services Development Funds, but Southeastern HSAs are prepared to move rapidly in implementing the resources development portion of the Act, having developed a solid base by concentrating on the health planning portion so far during the conditional designation period.

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PREFACE

This report briefly summarizes the *Progress through Participation* -- in Health Planning in the Southeast -- that has been achieved through the active involvement of many thousands of residents of the 41 Southeastern Health Service Areas during the past year and a half.

As the Health Systems Agencies move into full designation status, these residents -- all of them either consumers or providers of health care, many of them representing political constituencies as elected public officials or representing various special interest groups involved in the broad spectrum of health care, most of them embracing the overriding importance of improving health care while containing costs -- continue to donate enormous amounts of personal and professional time to health planning.

Beyond the compilation of numbers -- numbers of plans developed, numbers of dollars saved through HSA review recommendations, numbers of reviews performed -- the statistics presented in this report reflect a documented commitment to local health planning on the part of these thousands of residents and a dedication to achieving success in these important endeavors.

In part, this report serves to recognize that critically important commitment of interest, time, and spirit of cooperation that has been both the foundation and superstructure upon which the Congressional intent of the National Health Planning and Resources Development Act has been implemented in the Southeast.

That Act -- Public Law 93-641 -- was signed by the President three years ago this month. Eighteen months ago, most of the HSAs in the Southeast received their initial funding from the Department of Health, Education, and Welfare.

Progress since that time has been a direct result of the *Participation* of many more interested and concerned citizens than can be named in the space limitations of this summary report.

January 30, 1978

CHRONOLOGY

SELECTED EVENTS

Public Law 93-641, the "National Health Planning and Resources Development Act of 1974," signed by the President	January 4, 1975
Health Service Areas designated by the Secretary of Health Education, and Welfare	September 2, 1975
Bureau of Health Planning and Resources Development (DHEW) issued announcement about Designation and Funding of Health Systems Agencies, setting January 19, 1976, as deadline for applications	October 20, 1975
DHEW Region IV Office (Atlanta, GA) sent application kits to potential Southeastern Health Systems Agency Applicants	November 19, 1975
DHEW published Regulations for Health Systems Agencies Designation and Funding	March 26, 1976
First Health Systems Agencies designated by DHEW in Southeast	April 1976
Southeastern Health Systems Agencies received initial funding from DHEW	June 1976
Joint Conference Report of Congress on legislation to extend health planning programs called for DHEW review of a number of matters concerning the implementation of Public Law 93-641	July 14, 1977
Public Law 95-83, Health Planning Extension, signed by the President, extending programs under the National Health Planning and Resources Development Act through September 30, 1978	August 1, 1977
DHEW published proposed National Guidelines for Health Planning	September 23, 1977
First meeting of National Council on Health Planning and Development, authorized by Public Law 93-641 to advise DHEW with respect to the development of national guidelines for health planning	September 23, 1977

PURPOSE

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Public Law 93-641 Section 2.(b)

PURPOSE

"It is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and state planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy."

RESPONSIBILITY

Public Law 93-641 Section 1513.(a)

RESPONSIBILITY OF HEALTH SYSTEMS AGENCIES

"Each health systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency, for the purpose of --

"(1) improving the health of the residents of a health service area,

"(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

"(3) restraining increases in the cost of providing them health services, and

"(4) preventing unnecessary duplication of health resources."

NATIONAL PRIORITIES

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Public Law 93-641 Section 1502

NATIONAL HEALTH PRIORITIES

"The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

"(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

"(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

"(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

"(4) The training and increased utilization of physician assistants, especially nurse clinicians.

"(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

"(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act.

"(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

"(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

"(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

"(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services."

LOCAL PRIORITIES

All but three of the Southeastern HSAs have already developed and established local health plans -- called health systems plans (long-range goals) and annual implementation plans (short-range objectives) -- in each of the health service areas.

In accord with the provisions of the National Health Planning and Resources Development Act, each of these plans includes "a detailed statement of goals describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area, and which are responsive to the unique needs and resources of the area."

Local health plans will also take into account and be consistent with the national guidelines for health planning policy respecting supply, distribution, and organization of health resources and services, when those national guidelines are finally issued. Local priorities are established by residents at the health service area level, and as pointed out recently by the Secretary of HEW, "the local plans should, and indeed must, recognize special local circumstances and requirements, and the guidelines will provide for recognizing such circumstances."

Mrs. Sally Berger, Chairperson of the National Council on Health Planning and Development, established by Congress to advise the Secretary of HEW about the development of national guidelines, was quoted as noting recently that "The strength of national health planning will come not from rigid requirements from above, but by flexible national guidelines, which local circumstances and special needs can modify or augment at the local level."

Concurrence with the local priority approach was again reiterated by the U.S. House of Representatives early in December 1977 when it voted 357-0 to approve a resolution expressing the sense of Congress that national health planning guidelines must assure sufficient flexibility for Health Systems Agencies to vary from the guidelines in developing their local plans.

Extensive local data analyses and coordinated opportunities for insuring the participation of residents are key ingredients used by the Southeastern HSAs in making certain that their health plans contain local priorities responsive to the unique local needs identified by residents of the communities and areas they serve.

HEALTH SYSTEMS AGENCIES

All of the Southeastern HSAs are nonprofit corporations formed expressly for the purpose of engaging in health planning and development functions, with governing bodies whose members are all health service area residents serving without pay. During the first year and a half of the period of conditional designation, 55.5 percent of the residents who served on HSA governing bodies in the Southeast have been consumers, with the remaining 44.5 percent of the members being providers of health care.

Southeastern health service areas, designated by the Secretary of HEW on September 2, 1975, range in population size from 217,000 to 2,345,000. Slightly more than half of the health service areas in the Southeast have fewer than 750,000 residents each. Five of the areas have boundaries encompassing parts of two states and one health service area includes an entire state (Mississippi).

Seventeen of the Southeastern HSAs are new entities, formed by interested consumers, providers, and public elected officials specifically for the purpose of undertaking health planning and development functions. They mostly serve geographic areas where no areawide comprehensive health planning activities had been initiated previously. The other 24 Southeastern HSAs are corporations newly formed under the provisions of the National Health Planning and Resources Development Act, but with a background of experience and previous areawide involvement through predecessor community planning groups such as comprehensive health planning agencies.

The 41 Southeastern HSAs are listed by state beginning on page 17, together with their addresses and the names of their Executive Directors.

PROGRESS

Planning

During the past year and a half, Southeastern HSAs assembled data and analyzed the status of the health of residents, the status of the health care system, patterns of utilization of health resources, and other factors. With the participation of health service area residents, results of these analyses were combined with community perceptions of health needs to establish local goals and objectives.

Detailed health plans and work programs for achieving those community-identified goals and priorities have been developed already for 38 of the 41 health service areas in the Southeast. Copies of the plans were made widely available throughout the areas for review and use by consumers, providers of health services, government agencies, and other planning and development organizations.

- Before the adoption of their health plans, the Southeastern HSAs conducted 213 widely publicized public hearings to obtain comment and suggestions. At least 30 days prior to the public hearings, the HSAs published in area newspapers notices of consideration of the proposed plans, the time and place of the public hearings, the place(s) at which interested persons could review the draft plans in advance of the public hearings, and the place and time during which written comments could be submitted to the HSAs.

- Besides the 1,200 HSA governing body members who were present at the public hearings about the proposed health plans, 5,500 other interested residents participated in this process through attendance at these hearings.

- In addition to developing appropriate informal working relationships with various community groups, government agencies, health providers, and other planning and development organizations, Southeastern HSAs prepared and signed formal memorandums of agreement with a total of 412 organizations and agencies to insure coordination of planning efforts.

  These included State Health Planning and Development Agencies, Professional Standards Review Organizations, End-Stage Renal Disease Network Coordinating Councils, Councils of Government, Area Planning and Development Commissions, and other health systems agencies. These memorandums have formed the foundation for cooperation and mutual accountability among the many tax-supported and private planning efforts operating at the local, state, and national levels.

PROGRESS

Implementation

Although delays in publishing DHEW regulations affected the overall review process, most Southeastern HSAs entered this activity early in their conditional designation period, basing their reviews on statewide plans that stemmed from earlier comprehensive health planning efforts and local review processes undertaken in conjunction with federally funded health programs such as Medicare.

During the first year and a half of operation, Southeastern HSAs reviewed 2,943 applications or projects for proposed capital expenditures by health care facilities and/or proposed spending of federal health dollars.

Proposed spending totaled $2,495,000,000, with the HSAs recommending disapproval in 235 instances whose proposed spending added up to $367,180,000. These figures do not include applications or project proposals whose formal filing was withdrawn or modified after HSA advice and consultation with potential applicants.

- Six hundred and fifty-eight public hearings were conducted by the Southeastern HSAs in conjunction with reviews of applications or projects for proposed capital expenditures and/or proposed spending of federal health dollars. Sixteen thousand interested residents attended these public hearings to take advantage of the opportunities to participate in the process of local decision-making about health care expenditures affecting their communities.

- Southeastern HSAs have assisted in the development and preparation of 513 grant or contract applications and/or projects designed to improve health in their health service areas. At the time of this report, 304 such projects and applications had been approved for funding and implementation by various federal and other health program support sources.

- In all, Southeastern HSAs responded to 2,679 requests for technical assistance during the first year and a half of the conditional designation period. Besides this type of participation in community health planning and development endeavors, the HSAs served as a central community source of health and related planning statistics, providing in this short time period the answers to 7,000 requests for information and data.

PARTICIPATION

People

During the past eighteen months, 2,509 residents participated in the health planning and development process as elected or appointed members of Southeastern HSA governing bodies. According to definitions in the National Health Planning and Resources Development Act, 55.5 percent of these participants are classified as consumers, the other 44.5 percent as providers of health care.

A total of 365 public elected officials served as members of Southeastern HSA governing bodies. Public elected officials are grouped by DHEW regulations into a special category of governing body membership that includes 1) representatives of public agencies concerned with health, 2) public elected officials, and 3) other representatives of governmental authorities. All together, persons representing the three types of membership in this special category were limited by DHEW regulation to not more than 33.3 percent of the total governing body membership. During this part of the conditional designation period, public elected officials alone comprised 14.6 percent of the individuals who served on Southeastern HSA governing bodies.

A number of approaches have been adopted by the Southeastern HSAs to provide opportunities for participation of those individuals who were not elected or appointed to the HSA governing bodies during this particular period of operation. This report section describes some of those approaches, and the section on Public Information further details activities undertaken to provide and promote opportunities for participation. These activities are in keeping with the desire recently reiterated by DHEW to maintain an HSA commitment to encourage public involvement in the planning process. Early DHEW guidance to HSA applicants (November 1975) established the need for this commitment by pointing out: "Because of the composition requirements required by statute, it may be very difficult to assure that each organization which is of the opinion that it should have one or more representatives on the governing body indeed has such representation. However, through rotation of membership, community involvement, public meetings, letters, access to members of the governing body, etc., there are means for viable input from 'unrepresented agencies' in the decision-making of the governing body."

- HSA governing bodies in 17 of the Southeastern health service areas decided to form subarea advisory councils, as permitted by the National Health Planning and Resources Development Act. A total of 2,650 residents (54.8 percent consumers) participated in the health planning and development process through this avenue.

- Besides the 5,159 residents who served on governing bodies, executive committees, and subarea advisory councils, the Southeastern HSAs had the benefit of active participation of 4,000 other residents (non-governing body members) on various committees, task forces, technical assistance groups, and other such advisory and informational participating groups.

- Southeastern HSA governing bodies gathered to conduct business a total of 690 times during the first year and a half of operation, more than twice the minimum number of meetings required by their conditional designation agreements. Attendance at these meetings -- all open to the public -- included a total of 14,000 governing body members plus 10,500 other interested consumers, providers, and public elected officials.

- Twenty-two thousand and three hundred residents chose to confirm their interest in participating in the health planning and development process by attending the 1,007 meetings of the Southeastern HSA governing body executive committees and subarea advisory councils.

PARTICIPATION

Time

All told, during the past year and a half, Southeastern health service area residents contributed 204,000 hours of personal and professional time to HSA activities, exclusive of preparation and travel time. Such time includes that of governing body members and other interested residents while participating in governing body meetings, executive committee and other committee meetings, task force and technical assistance group workshops, orientation and training sessions, and subarea advisory council meetings.

For purposes of considering the total investment of time and effort voluntarily contributed to participation in the health planning and development process, these hours combine to reflect a total of 106 years of participation, calculated using a 40-hour work week. These figures do not include the vast investment of time spent by residents participating in the 871 public hearings held in conjunction with HSA reviews and health plan development, nor do they include the time spent in 931 public informational and educational forums.

Because of the large geographic size of the health service areas served by most Southeastern HSAs, participants have logged thousands of hours traveling hundreds of thousands of miles to come together to discharge their responsibilities in the health planning and development process. They have also spent a significant amount of time reading and studying materials to be fully prepared to accomplish their duties effectively.

It is impossible to calculate the total dollar value of all the volunteer time invested by residents in these endeavors. This is especially so in light of the wide range of participant incomes and in recognition of the critical importance of the non-monetary, non-measurable contribution of experience and insight offered by the broad representation of community interests across the range of retired persons, government workers, low-income families, students, business and industry representatives, housewives, health care professionals, and many, many others.

- A total of 49,800 hours were spent by Southeastern HSA governing body members in attendance at governing body meetings, exclusive of preparation time for study of advance meeting materials, and not counting travel time to and from the meetings.

- Attendance of governing body members at Southeastern HSA executive committee meetings, again exclusive of preparation and travel time, totalled an investment of 11,250 hours.

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- Governing body member attendance at meetings other than governing body and executive committee meetings required a total of 43,900 hours, not counting preparation and travel time. Such meetings included work of the nominating committees, public information committees, community relations committees, task forces and technical assistance groups. This commitment of time was in addition to governing body member attendance at public hearings, meetings, forums, educational sessions, speaking engagements, and so forth.

- In the 17 Southeastern HSAs whose governing bodies decided to form subarea advisory councils, members of those councils spent a total of 51,300 hours in council meeting attendance, not counting preparation or travel time.

- Residents other than those serving on Southeastern HSA governing bodies recorded 47,600 hours in HSA committee, task force, technical assistance group, and similar working group activities, exclusive of preparation and travel time.

PUBLIC INFORMATION

Each of the Southeastern HSAs adopted and published -- in generally circulated newspapers throughout its health service area -- official notices of policies and procedures for making its records and data available to the public for inspection and copying. Available through these policies and procedures are all HSA records and data made or received by the HSAs in connection with their performance of HSA functions, and retained as evidence of the HSA's functions, policies, decisions, procedures, operations, programs, and other health planning and development activities.

Each Southeastern HSA also prepared and widely distributed an Annual Report concerning its activities. These Annual Reports were sent to all public libraries throughout the health service areas, and to the 1,300 newspapers, 1,200 radio stations, and 250 television stations serving residents of the Southeast. Official notices announcing the availability of the Annual Reports at no cost upon request were published in newspapers in each health service area. The Annual Reports included the health plans developed by the HSAs; detailed descriptions of HSA progress in meeting the objectives of its work program; a list of the HSA income, expenses, assets, and liabilities; a list of residents serving as members of the HSA governing body and executive committee; and the names of the HSA staff.

- Southeast HSAs sponsored 931 local gatherings and forums as informational, educational, and participatory local health planning and development sessions. These were in addition to the public hearings for input on drafts of proposed health plans, public hearings in conjunction with reviews of proposed spending, and governing body and executive committee meetings. A total of 14,600 residents attended these local sessions to obtain information and to express their opinions and make suggestions regarding health matters in their communities.

- As another approach to encouraging participation of residents, HSA representatives fulfilled 1,800 speaking engagements to civic, fraternal, government, professional, community, and other organizations, associations, groups and clubs. In all, more than 65,000 consumers, providers of health care, and public elected officials comprised the audiences for these presentations, which usually included detailed question/answer sessions. These presentations were in addition to the 3,500 public hearings, public meetings, governing body meetings, executive committee meetings, and subarea advisory council meetings sponsored by the HSAs.

- As more and more individuals and organizations took advantage of the many opportunities to participate in the health planning and development process, Southeastern HSA mailing lists grew to include -- according to actual count as of January 1, 1978 -- a total of 50,185 addressees. During this portion of the conditional designation period, HSAs used the direct mail approach 5,700 times, sending announcements and notices to mailing list addressees as a supplement to regular media news releases and paid advertisements.

- Specialized newsletters containing key information about the health planning and development process and opportunities for participation were prepared regularly by the Southeastern HSAs, and a total of 400 issues (with each issue representing as many as several thousand copies) were sent free to thousands of individuals, organizations and agencies throughout the health service areas.

- Local media outlets participating in the health planning and development process in the Southeast include 1,300 newspapers, 1,200 radio stations, and 250 television stations. During the past 18 months, Southeastern HSAs prepared 2,500 news releases for use by media outlets as part of the overall approach to informing the community and stimulating further interest and involvement in HSA activities. In addition, local media outlets regularly prepared their own news stories and editorials covering HSA activities, and HSA representatives appeared often on radio and television programs to discuss their planning efforts and to answer questions.

- Besides the free publicity obtained by the HSAs, 3,000 paid newspaper advertisements were purchased to carry out the public notice requirements of the National Health Planning and Resources Development Act, insuring community awareness of meeting dates and locations, public hearing information, availability of HSA records and data, availability for public review of proposed and final plans and HSA applications for designation, Annual Reports, and related announcements.

WHAT NEXT?

Without regard to race, creed, age, sex, or occupation, all residents share in having some form of health status -- they are either well or ill, handicapped or handicap-free, physically and mentally healthy or disabled. A majority of residents also share in paying for the health care system through which services are received, either through payment of taxes, insurance premiums, employment fringe benefits, or direct payment for care.

Now, through the network of health systems agencies, more and more residents are also sharing the responsibility and authority for shaping the health care delivery system and ultimately influencing the effect of that system on their health.

Early in 1978, activities will be undertaken to consider the extension of this national program of locally controlled health planning and resources development when current legislative authority expires September 30, 1978.

Significant progress has been made in the year and a half since DHEW provided initial operating funds to the HSAs, notwithstanding continuing delays in the issuance of regulations and limited HSA funding. The HSAs have operated during the conditional designation period with far less than the annual 50 cents per capita authorized by PL 93-641.

Moreover, Congress has not yet appropriated any monies for the Area Health Services Development Fund authorized by the National Health Planning and Resources Development Act. PL 93-641 authorized slightly more than $35,000,000 in Area Health Services Development Funds with which Southeastern HSAs are to make grants and contracts -- in accordance with local priorities established in their plans -- to public and nonprofit private entities to assist in the planning and development of projects and programs which the HSAs determine are necessary for the achievement of the health system described in their plans. Assuming these funds are appropriated for the program by Congress, the HSAs will initiate this resource development activity as part of their early full designation responsibilities.

Full designation will also bring greater review responsibilities, as the HSAs begin to review all institutional health services offered in their health service areas, and make recommendations respecting the appropriateness of such services. Moreover, the HSAs will review and make recommendations respecting the need for new institutional health services proposed to be offered or developed in their health service areas.

Perhaps the greatest resource developed during this part of the conditional designation period is the interest and participation generated among so many different segments of the population for whom the HSAs exist. Continued application of this resource should result in even more effective accomplishment of the goals of the National Health Planning and Resources Development Act if and as Congress moves to appropriate sustaining operational funds and DHEW progresses in its development and publication of regulations.

HSA ADDRESS LISTING

Southeastern Health Systems Agencies

ALABAMA

Alabama Health Service Area 1

North Alabama HSA
Huntsville-Madison County Jetport
P.O. Box 6145
Huntsville, AL 35846
Executive Director:
Dennis Q. Copheim

Alabama Health Service Area 2

West Alabama Health Council, Inc.
P.O. Box 1488
Tuscaloosa, AL 35401
Executive Director:
Dr. Elizabeth Cleino

Alabama Health Service Area 3

Birmingham Regional HSA, Inc.
1612 10th Avenue South
Birmingham, AL 35205
Executive Director:
Albert H. Rohling

Alabama Health Service Area 4

Health Systems Agency
P.O. Box 264
Gadsden, AL 35902
Executive Director:
John A. Brown

Alabama Health Service Area 5

Southeast Alabama HSA
P.O. Box 11292
Montgomery, AL 36111
Executive Director:
David W. Carter

Alabama Health Service Area 6

Southwest Alabama Health Planning Council
812 Downtowner Boulevard, Suite E
Mobile, AL 36609
Executive Director:
Jeff Caskey

Alabama Health Service Area 7

(See Georgia Area 5)

FLORIDA

Florida Health Service Area 1

Florida Panhandle HSA, Inc.
812 West 11th Street
Panama City, FL 32401
Executive Director:
Gregory R. Shanika

Florida Health Service Area 2

North Central Florida Health Planning Council, Inc.
2002 N.W. 13th Street, Suite 103
Gainesville, FL 32601
Executive Director:
P. Jan Hughey

Florida Health Service Area 3

HSA of Northeast Florida Area III, Inc.
1045 Riverside Avenue, Suite 260
Jacksonville, FL 32204
Executive Director:
Fred J. Huerkamp, Jr.

Florida Health Service Area 4

Florida Gulf HSA, Inc.
The Bullard Executive Center
10051 Fifth Street N., Suite 253
St. Petersburg, FL 33702
Executive Director:
Edward L. Perrine

Florida Health Service Area 5

HSA of East Central Florida, Inc.
924 N. Magnolia Ave.
P.O. Box 6061-B
Orlando, FL 32803
Executive Director:
John W. Beaton, Jr.

Florida Health Service Area 6

South Central Florida Health Systems Council, Inc.
P.O. Box 1106
1390 Main Street, Suite 730
Sarasota, FL 33678
Executive Director:
Dr. Patricia Paulson

Florida Health Service Area 7

Health Planning Council, Inc.
4423 Westroad Drive
West Palm Beach, FL 33407
Executive Director:
Richard D. Warfield

Florida Health Service Area 8

Health Planning & Development Council
1164 East Oakland Park Blvd.
Ft. Lauderdale, FL 33301
Executive Director:
Clifford Anderson, Jr.

Florida Health Service Area 9

HSA of South Florida
3050 Biscayne Blvd., Suite 601
Miami, FL 33137
Executive Director:
Robert T. Jones

GEORGIA

Georgia Health Service Area 1

(See Tennessee Area 3)

Georgia Health Service Area 2

Appalachian Georgia HSA
P.O. Box 829
Cartersville, GA 30120
Executive Director:
Charles P. McJunkin

Georgia Health Service Area 3

North Central Georgia HSA, Inc.
Kennesaw Life Building, Suite 700
1447 Peachtree Street, N.E.
Atlanta, GA 30309
Executive Director:
Robert A. Youngerman

Georgia Health Service Area 4

East Central Georgia HSA, Inc.
Georgia Railroad Bank Building
Suite 1114
Augusta, GA 30902
Executive Director:
William T. McKettrick

Georgia Health Service Area 5

HSA of Central Georgia, Inc.
P.O. Box 2305
Warner Robins, GA 31093
Executive Director:
Don J. Trantow

Georgia Health Service Area 6

Southwest Georgia HSA, Inc.
P.O. Box 4229
Albany, GA 31706
Executive Director:
Alex Kemp

Georgia Health Service Area 7

Southeast Georgia HSA, Inc.
P.O. Box 1455
Brunswick, GA 31520
Executive Director:
Pat Jansen

KENTUCKY

Kentucky Health Service Area 1

Kentucky HSA West, Inc.
1941 Bishop Lane, Suite 401
Louisville, KY 40218
Executive Director:
Laurel True

Kentucky Health Service Area 2

East Kentucky HSA, Inc.
P.O. Drawer 557
Winchester, KY 40391
Executive Director:
Tony Goetz

Kentucky Health Service Area 3

(See Ohio Area 1)

MISSISSIPPI

Mississippi HSA, Inc.
Watkins Building, Suite 400
510 George Street
Jackson, MS 39201
Executive Director:
Philip W. Laird

NORTH CAROLINA

North Carolina Health Service Area 1

Western North Carolina HSA, Inc.
One Northsquare
Morganton, NC 28655
Executive Director:
Charles M. Moeller

North Carolina Health Service Area 2

Piedmont HSA, Inc.
2120 Pinecroft Road
Greensboro, NC 27407
Executive Director:
Ned B. Clark

North Carolina Health Service Area 3

Southern Piedmont HSA
One Charlottetown Center, Suite 425
1300 Baxter Street
P.O. Box 4588
Charlotte, NC 28204
Executive Director:
Eugene Goeller

North Carolina Health Service Area 4

Capital HSA, Inc.
501 Willard Street
Durham, NC 27701
Executive Director:
George M. Stockbridge

North Carolina Health Service Area 5

Cardinal HSA, Inc.
202 West 27th Street
Lumberton, NC 28358
Executive Director:
Gary L. Jennings

North Carolina Health Service Area 6

Eastern Carolina HSA
Suite 405, Minges Building
P.O. Drawer 7306
Greenville, NC 27834
Executive Director:
Roy Selby

OHIO

Ohio Health Service Area 1

Health Planning & Resources Development
Association of Central Ohio River Valley
19 Garfield Place, Suite 700
Cincinnati, OH 45202
Executive Director:
James Sandmann

(Ohio Health Service Area 1 includes parts of Kentucky Congressional Districts 4 and 6)

SOUTH CAROLINA

South Carolina Health Service Area 1

South Carolina Appalachian Health Council
211 Century Drive, Building D
P.O. Box 6708
Greenville, SC 29606
Executive Director:
James F. Keasler

South Carolina Health Service Area 2

Three Rivers HSA, Inc.
3325 Medical Park Road
Columbia, SC 29203
Executive Director:
Dennis Caldwell

South Carolina Health Service Area 3

Pee Dee Reg HSA, Inc.
P.O. Box 5959
Florence, SC 29502
Executive Director:
W. L. Moore, Jr.

South Carolina Health Service Area 4

Palmetto-Lowcountry HSA, Inc.
107 West 6th North Street
Summerville, SC 29483
Executive Director:
Lynn Beasley

TENNESSEE

Tennessee Health Service Area 1

Appalachian Regional Center for the Healing Arts
P.O. Box 3520
Johnson City, TN 37601
Executive Director:
Ray Orren

Tennessee Health Service Area 2

East Tennessee Health Improvement Council, Inc.
10903 Lake Ridge Road
Knoxville, TN 37922
Executive Director:
Robert Johnson

Tennessee Health Service Area 3

Georgia-Tennessee Regional Health Commission
201 Zayre Building
401 West 9th Street
Chattanooga, TN 37402
Executive Director:
Harry D. Shrago

Tennessee Health Service Area 4

Middle Tennessee HSA, Inc.
2 International Plaza Drive, Suite 200
Nashville, TN 37217
Executive Director:
Robert E. Norris

Tennessee Health Service Area 5

West Tennessee Health Improvement Association, Inc.
1804 Highway 45 Bypass
Watkins Towers, Suite 304
Jackson, TN 38301
Executive Director:
Ronald Reid

Tennessee Health Service Area 6

Mid-South Medical Center Council
Medical Center Towers Building
Suite 1200
969 Madison Avenue
Memphis, TN 38104
Executive Director:
Norman L. Casey

Mr. ROGERS. Thank you very much.

I commend you on doing this study; it shows considerable more progress than is indicated in the General Accounting Office study.

Mr. RHOLING. Yes, sir.

Mr. ROGERS. And you would indicate what, about 14.5 to 15 percent of capital investment reviewed have been disapproved?

Mr. ROHLING. That is correct. Our figures are now showing 15 percent and again I would like to reiterate that that really does not represent the cost savings totally. There are other factors such as the——

Mr. ROGERS. Negotiated.

Mr. ROHLING. Yes.

Mr. ROGERS. Why don't you build 150 instead of 300 beds?

Mr. ROHLING. That is correct.

Mr. ROGERS. Well, I think any information you can supply to us of that nature as you continue to look at the HSA's would be helpful to the committee.

Should each HSA prepare a budget and submit it?

Mr. ROHLING. Yes, sir; we think that is a good approach. I think our agencies are in favor of submitting budgets. We in fact do submit budgets. The budgeting process has been sort of readjusted every so often over the last several years. We would not be opposed at all to submitting budgets, letting our requirements be known, and we would hope that we could live within the constraints of good sound budgeting, and I would think we can.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. Chairman, I want to commend these gentlemen. It has been my good fortune to meet with some of the members of the HSA's throughout the Southeast and in Kentucky particularly and I found them to be an outstanding group of people, Mr. Chairman, the very best. Certainly I would like to see this funding increased for 3 years rather than limited to 1 year. If you are going to be effective, I think that you should have this.

The level of intelligence of these people who are engaging in this work voluntarily is quite high and we are very fortunate, as I see it, to have them. Mr. Chairman, as I understand it—of course since 1974 I could have forgotten—under the Health Planning Act were not the HSA's supposed to have charge of all of the spending for health in those areas? All health, is that not correct, Mr. Chairman?

Mr. ROGERS. Certainly all Federal funding is to have their review and approval.

Mr. CARTER. Yes, sir.

Mr. ROGERS. And then they are to help determine the need on all facilities.

Mr. CARTER. Yes, sir; and I believe to determine where all health spending in that area should go. I believe that is how it was written. I hope my memory does not fail me on that.

What is your opinion of the administration's proposal on HMO's?

Mr. ROHLING. I think, Dr. Carter, that it would be our feeling that the HSA's ought to be able to treat all health providers in an equal fashion whether they be government sponsored, whether they

be HMO's, whether they be privately sponsored or whether they be the Veterans Administration. I think we have the capability to look at the local scene to make determinations about our local scene and certainly we are sympathetic with the health maintenance organization approach. We would like to maintain a very substantial input into the review responsibilities for health maintenance organizations.

Mr. CARTER. Yes, sir. What do you think about the cap that we are putting on capital spending? Can we live with that, or not?

Mr. ROHLING. It is hard to say. In our own Southeast in the past 18 months—not a year but 18 months—we had total requests presented to us of $2.5 billion which would in effect be the national cap for 1 year. Certainly I think we have got to have some caps somewhere but precisely where it is we are not prepared to say.

Mr. CARTER. There is no question about that, but of course that is up to you gentlemen.

Yes, Mr. Goetz.

Mr. GOETZ. On that particular question I would just reiterate a point that was raised earlier today that in some areas there is a great deal yet to be developed, a great deal yet to be done. The HSA's are generally finding these areas of need and must have the freedom, I believe, to initiate programs in those areas to meet those needs and a cap program might be counterproductive to that. My own personal opinion would be that I would be extremely concerned about a cap of $2.5 billion for the country.

Mr. CARTER. What are we going to do about the $4 billion we receive in contributions from our good, compassionate, wealthy people who contribute this amount each year? Are we going to say, no, we don't want it; you keep it and go to the Riviera with it, or are we going to put it to good use and help poor people throughout our country?

Mr. ROHLING. I think we definitely need to put it to good use, Dr. Carter. I think we should encourage those contributors that their donations are given for things that are needed and our HSA's are in a position to point out where precisely the needs are in our communities.

Mr. CARTER. If a fellow gives $100,000, he likes to see a little plaque with his name on it, does he not, most of the time?

Mr. ROHLING. Yes, he does.

Mr. CARTER. Or perhaps his wife's name.

Now on the proposal of participation by public officials, would you give me your idea on that?

Mr. ROHLING. Yes, sir. I think we can say categorically that we are opposed to establishing quotas for any group to serve on the governing bodies of our organizations. We support the concept of representation from a broad point of view whereby the segments of our society are proportionately represented as best as we possibly can. Elected officials are certainly key figures; however, we would not like to assign a quota for them for several reasons. Many of them do not want to participate in the very difficult decisions that HSA's are forced to make and that will compromise their own political futures perhaps. I know our board members are extremely pressured

on difficult issues and legislators and elected officials are often put in very difficult positions in that case.

Mr. CARTER. I can understand how that is. Perhaps you will have pressure from—you are from North Carolina, are you not?

Mr. ROHLING. Alabama.

Mr. CARTER. Alabama. I see.

Well, probably Sylacauga would want a hospital and all the elected representatives from Sylacauga would want that and if they didn't, off would go their heads in the next election, is that right?

Mr. ROHLING. That is right.

Mr. CARTER. All right.

Mr. ROHLING. We do, however, feel that the elected official has a very substantial role to play and we would like for each community to be in a position to work with the elected officials in determining that role.

Mr. CARTER. Thank you very kindly for your presentation. It has been a pleasure on my part to have you here and I am pleased by the high caliber of representation you gentlemen afford.

Thank you.

Mr. ROGERS. What is the situation in the southeast on over-bedding or under-bedding?

Mr. ROHLING. I think it varies, Congressman. I believe in the metropolitan areas we would have an over-bedded situation on the basis of four beds per thousand. In the less urban areas we would have the reverse situation. One of the difficulties is we have tended to come along a little slower than perhaps the rest of the country over the past number of decades but the south is now catching up and the specialized services and the technology in the most recent years has now been centralized in medical centers in most of our metropolitan areas and I think we can see that trend continuing.

Mr. ROGERS. What is the general feeling in the south—I presume you talked to some of the other planning experts—as far as duplication of equipment or excess equipment?

Mr. ROHLING. We have that problem in the Southeast as well as in other parts of the country. The boom in technology has centainly created the opportunity for individual institutions to compete with one another for that equipment and to duplicate it from their point of view from time to time. It is important for the health systems agencies to be in a position to point out where duplications do occur.

Some discussions occurred about highly sophisticated equipment in other settings and institutions. I think generally our HSA's would feel that certain types of equipment hopefully named by legislation would be included in the certificate of need provision regardless of its location. Now we think that by naming it it is precisely defined and there is no question about it.

Mr. ROGERS. Well, rather than naming it, suppose a certain money figure was set, say $150,000 or above?

Mr. ROHLING. Well, the escalation of costs is such that any figure you establish in 1978 would probably not be valid for very long.

Mr. ROGERS. Well, you can still grant it. You don't let them have it. It just says if it is $150,000 or above on a single piece of equipment, then it would just be reviewed.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Yes, Dr. Carter.

Mr. CARTER. Of course you are a lawyer and I am not but if the facility which applies for this $150,000 is not a recipient of Federal funds, would the Constitution permit you to keep them from purchasing whatever they wanted?

Mr. ROGERS. Well, I have not looked into the constitutionality of it but you certainly would not have to reimburse them from the Federal funds.

Mr. CARTER. You are quite right on that but certainly if you want——

Mr. ROGERS. Without a certificate-of-need approval?

Mr. CARTER. Personally I think there is a serious constitutional question if they do not receive Federal funds.

Mr. ROGERS. All right.

How did your agency, for instance, Birmingham, select its board?

Mr. ROHLING. There was an areawide nominating committee which in fact solicited nominations from every possible source that it could think of, including notification of the public through all the media opportunities. Then a series of nominations was returned and an initial board was then assigned by that nominating committee.

Mr. ROGERS. Do you think consumers are adequately represented when the board itself is self-selected?

Mr. ROHLING. Repeat that, please.

Mr. ROGERS. Say the board is getting a successive void. Should the current board select new board members?

Mr. ROHLING. Our experience demonstrates in the southeast that that is not a bad model to follow. We do not think it is the only model but we think that it is a workable model. The opportunity for one-third of the board in most cases to rotate off each year and to be replaced by new board members I think is certainly there and we would invite your inquiry into how that has worked.

We have really had the opportunity for only one election since the inauguration as health system agencies. I think an inquiry into that election process would turn out the fact that there are a number of new board members that have been elected to the board since the inception of the agencies. In my own organization I can testify to that and I think the others can probably do as well.

Mr. ROGERS. So you think it is all right to have a self-selecting process?

Mr. ROHLING. I would say that the process is not so much self-selecting but the process is open whereby nominations can occur from any source and an individual who qualifies for a certain slot on the board, whether it be an ethnic slot or a low income slot, every person who is nominated for that slot, has an equal chance to be elected from that category of consumers that are nominated. I think from that point of view the person or the group that selects them certainly is important but less important than the openness of the process.

Mr. ROGERS. I keep hearing that doctors and dentists don't have enough representation on HSA's. What is your opinion?

Mr. ROHLING. I think every area might have to deal with its own situation. Certainly in my State that is not the case.

Mr. ROGERS. What is the percentage there?

Mr. ROHLING. The percentage? There are more physicians on the board of directors of the Birmingham Regional Health Systems Agency than any other professional group.

Mr. ROGERS. Are there more physicians than hospitals administrators?

Mr. ROHLING. Yes, there are twice as many physicians as hospital administrators.

Mr. ROGERS. It is still within the 40 percent, or do you have 49 percent?

Mr. ROHLING. We have 49 percent providers.

Mr. ROGERS. Fifty-one percent consumers?

Mr. ROHLING. Yes.

Mr. ROGERS. Should insurance companies be consumers or providers?

Mr. ROHLING. They are currently listed as indirect providers and I think we find that to be a good designation.

Mr. ROGERS. As purchasers you don't think they should be consumers?

Mr. ROHLING. They certainly are consumers as purchasers but as payors they are also providers. The major purchasers, for example, the corporate structure, are certainly very good consumers and very god consumers for us to attract to our program.

Mr. ROGERS. What about people who are active in the heart association and the cancer association taking an active interest? How do you classify them?

Mr. ROHLING. We generally classify those as consumers if they are voluntary members in a voluntary organization. Now if they are in a Government agency and have control of funds for service programs, we would classify them as indirect providers.

Mr. ROGERS. What about the wife of a doctor?

Mr. ROHLING. The wife of a physician is an indirect provider.

Mr. ROGERS. Even though she may be a volunteer in the heart association?

Mr. ROHLING. Even though she may be. It depends on the source of income.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Do you agree with that, that the wife of a doctor is a provider?

Mr. ROHLING. Are you asking me, sir?

Mr. CARTER. I was asking the chairman.

Mr. ROGERS. I will try to respond.

I don't know. I was just thinking. I presume she might have some bias from her husband's business and I guess that is why they had thought maybe she was not completely an independent and free consumer.

Mr. CARTER. You don't know my wife.

Mr. Chairman, I would say they propose in this legislation that we make the spouse a consumer. That was the point.

Thank you, sir.

Mr. ROHLING. One comment on that, Dr. Carter.

Mr. CARTER. Sir.

Mr. ROHLING. I think we favor the liberalizing of the concept of an indirect provider and particularly in those cases where it is very

questionable whether a person is an indirect provider or consumer. We would hope that we could not keep those people off our boards because they happen to be somewhat affiliated with a providing situation.

Mr. ROGERS. Suppose there is a woman doctor and her husband is a lawyer and he is on the heart association as a volunteer?

Mr. ROHLING. According to the current statute he is an indirect provider. That may need to be liberalized.

Mr. ROGERS. What about education for the consumers? Do you have any programs to give technical assistance and aid to the consumer members or should there be such programs?

Mr. ROHLING. Absolutely. I think we can say candidly that an HSA is not doing its job properly if it does not provide that. I think that HSA's have a necessity to do that. I cannot conceive of an organization trying to do its job without promoting and developing educational programs for all of its members, not only consumers but providers as well.

Mr. ROGERS. Now I also keep hearing that the current establishment has control of HSA's. Do you think that is a legitimate complaint?

Mr. ROHLING. You may have to evaluate one by one but I think collectively that is not a fair assessment.

Mr. ROGERS. I hear that if someone wants a new hospital there may be a tendency to let a current existing hospital expand or build a new facility rather than letting the new group come in.

Mr. ROHLING. That may well be for cost containment reasons. It is cheaper in most cases to expand an existing institution than it is to construct an entirely new facility with all the ancillary facilities that have to go along with it. Assuming accessibility to care is not a factor, the preferred alternative would be the less expensive one; namely, the expansion of an existing institution.

Mr. ROGERS. Well, suppose they both cost the same.

Mr. ROHLING. If they both cost the same and the accessibility factor is met, well, then it is a value judgment probably based on the reputation of the institution that is currently in operation. If it has a good reputation, it very likely would be given the nod by the local community.

Mr. ROGERS. So the bias might be toward the existing facility?

Mr. ROHLING. The bias might be on a proven track record which probably is a good basis upon which to make that decision, all other things being equal.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Yes, Dr. Carter.

Mr. CARTER. On that I don't think that would be bias, I just think it would be good sense, good judgment.

Mr. ROGERS. How many HMO's do we have in the southeast?

Mr. ROHLING. I do not know that information. We did not gather that. Not a great deal.

Mr. ROGERS. Is your group doing anything to help get HMO's established?

Mr. ROHLING. We have not taken any positive initiatives as an association. There are those of us individually in our own HSA's and our own health service areas that are promoting development of HMO's in our own communities.

Mr. ROGERS. Should the Governor be allowed to approve or disapprove a State health plan?

Mr. ROHLING. We have no association position on that. I will give you my personal opinion. I think the method that is currently established in the law for the approval of a State health plan is quite adequate.

Mr. ROGERS. Should the Governor appoint the chairman of the statewide Health Coordinating Council?

Mr. ROHLING. Again we have no association position on that. I think in many cases the Governor did appoint not officially but unofficially the chairman or at least suggested certain members. Appointing the chairman is a less political problem than the approval of the plan. The chairman has no vote normally. The council, a large body, would determine the action of the group, not the chairman.

Mr. CARTER. Would the chairman yield.

Mr. ROGERS. Yes.

Mr. CARTER. Should politics play a part really in health?

Mr. ROHLING. I think our job as HSA's is to depoliticize decisionmaking. Now that is a difficult thing to do all the same.

Mr. CARTER. It is certainly a situation to be wished, isn't it?

Mr. ROHLING. Yes, sir. I think it is our job to depoliticize it and I think as professional people we would want to do that.

Mr. CARTER. On a certificate of need should an HSA make that decision or should the Governor?

Mr. ROHLING. The regulatory authority rests in the State Health Planning and Development Agency.

Mr. CARTER. Yes.

Mr. ROHLING. The HSA's have substantial input into that decision.

Mr. CARTER. Yes, sir.

Mr. ROHLING. And we think that is appropriate.

Mr. CARTER. Mr. Goetz, have you any intensive nursery center closer than Lexington in your HSA?

Mr. GOETZ. No, sir; not at the present time. We have got three or four hospitals that we feel have the capability along with the manpower to provide this type of care and anticipate within the next year or so there will be at some regional level-two centers.

Mr. CARTER. We have lost some youngsters recently because of that. We have such a unit in Lexington and I would think in Covington, I am not sure, and Louisville.

Mr. GOETZ. And Knoxville.

Mr. CARTER. Knoxville. Paducah? I am not sure.

Mr. GOETZ. Paducah does not at the present time, no.

Mr. CARTER. Of course that is in a different HSA to yours.

What about coronary units? You have located one in Lexington, of course.

Mr. GOETZ We have got two in Lexington. There are coronary units of varying sizes throughout. Ashton will have something, Somerset will have something. I cannot remember now whether it is Hazard or Harlen in the system. Pikeville Methodist in Highlands.

Mr. CARTER. Do you think we will need more intensive infant care installations? Is that right?

Mr. GOETZ. I am very strong on the fact that we do and our data has shown that we need the level-two units probably before we need expansion of the level-three units at the present time.

Mr. CARTER. Now the composition of your board, really how many dentists, nurses, hospital administrators, and insurance salesmen do you have composing the provider portion?

Mr. GOETZ. This year our new board was elected in October. We have four physicians of varying types. One of these represents the health professional school, one is the county health officer in Pike County, one is a salaried pediatrician in the hospital system, and we have one private practitioner, general surgeon. We have two dentists. We have no nurses this year; as a matter of fact, we did have one last year and the election went a different way this year. We have two hospital administrators. We have one health care insurer. We have three indirect providers; one, whose wife is a nurse, happens to be chairman of our board. He is a geography professor but his wife is a nurse. We have a board member on an HMO—not federally qualified HMO but it does meet the State standards for HMO. I can't recall the other one at the present time, Dr. Carter.

I believe that is about it. We have a total of 13 providers, 17 consumers on our board.

Mr. CARTER. Thank you very kindly.

Thank all of you, gentlemen.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much. Your testimony has been most helpful to the committee and we are particularly pleased with the study that you submitted. Thank you for being here.

Mr. ROHLING. Thank you.

Mr. ROGERS. The next witnesses will form a panel of State legislators. I am very pleased Representative Elaine Gordon, chairman of the Health and Rehabilitative Services Committee, is here and I am particularly pleased to welcome her. I am glad to have her here from my State. I particularly welcome you.

Representative James Tallon, State Capitol, Albany, N.Y. We are very pleased to have you with us.

Representative Frank Traylor, chairman, Republican Council, State Capitol Building, Denver, Colo.

We welcome each of you. We are grateful for your being willing to share your thinking with the committee, it will be most helpful.

Each of your statements will be made a part of the record in full, and you may proceed as you desire.

STATEMENT OF HON. ELAINE GORDON (FLORIDA), CHAIRMAN, HEALTH AND REHABILITATIVE SERVICES COMMITTEE, ON BEHALF OF NATIONAL CONFERENCE OF STATE LEGISLATURES; HON. JAMES R. TALLON, JR., MEMBER OF THE ASSEMBLY, STATE OF NEW YORK; AND FRANK TRAYLOR, M.D., CHAIRMAN REPUBLICAN COUNCIL, DENVER

Miss GORDON. Mr. Chairman, first I have been designated as chairperson of this panel and I would like to just summarize the position of the National Conference of State Legislatures which I am submitting in writing in full and then each of us on the panel would like to make our briefer presentations as representatives from our own States.

Mr. ROGERS. Certainly. That would be fine. Thank you.

Miss GORDON. Mr. Chairman, before I begin the formal part of my testimony, I would like to read a brief quote which I believe captures so well in a few words what the plight of the State legislator is with respect to health policy. The quote is by Katharine Bauer, principal associate at the Harvard Center for Community Health and Medical Care, and was related in a speech by her to a health conference for State legislators last year.

> Your Governors want to put the lid on rising health care costs but don't want to take the political heat of reducing benefits or services. Your consumers don't want more taxes or higher Blue Cross premiums, but they do want a full service hospital down the street complete with an open heart surgery unit just in case. And they do want jobs constructing hospitals and nursing homes, supplying them and working in them. Also, both the providers of services and those that attempt to regulate them bring you their accounts—alas, often true—about the inequities and iniquities the other party perpetrates. Finally, after listening to all the experts, you pass apparently sensible, simple laws that you think will help straighten out our health care problems—only to watch many of them become fiscal or administrative disasters.

Mr. Chairman, I am sure you and the members of your subcommittee can relate to those remarks by Mrs. Bauer since you face many of the same expectations and frustrations but only at a different level in the Federal system.

My two colleagues and I appreciate very much the opportunity to appear before you to offer our views on the reauthorization of the National Health Planning and Resources Development Act, Public Law 93–641. I should point out that we are here today in somewhat of a dual capacity: As individual State legislators with divergent backgrounds and from very different kinds of States and as members of the National Conference of State Legislatures—an organization whose purpose is to bring representatives of the 50 State legislative bodies together to discuss intergovernmental issues and to speak with one voice on matters affecting State-Federal relations.

The observations and recommendations included in this testimony grew out of meetings conducted by the human resources committee of the National Conference of State Legislatures. That committee, of which I serve as vice chairperson, is chiefly responsible for making recommendations on health and welfare policy to the State-Federal assembly, SFA, of the NCSL. The human resources committee is composed of chairmen and ranking members of State legislative health and welfare committees.

The human resources committee met on two separate occasions recently and developed several recommendations with respect to the renewal of the health planning law. In that exercise, we were grateful for the participation of Bob Crane, professional staff member from the health subcommittee, who assisted us in our understanding of what the key issues would be during the debate over reauthorization.

The recommendations adopted by the human resources committee were considered and accepted unanimously by our State-Federal assembly. The SFA, for your information, includes over 500 State legislators representing all 50 State legislatures and both political parties.

Mr. Chairman, we believe that there are few public policy issues today more important than the assurance that our Nation's available health resources are distributed on the basis of need and in such a manner as to insure the maximum efficiency and cost-effectiveness of our health care system. The enactment of the Health Planning and Resources Development Act, Public Law 93–641, represents a good step in the furtherance of that goal. The concept of planning for a more effective and efficient allocation of our limited health resources is one which we fully endorse. The Congress deserves considerable praise for attempting to bring the various interested parties together through planning mechanisms designed to promote greater order and coordination to what has heretofore been a fragmented and very costly health care system.

While State legislators eagerly support the goals and purposes of Public Law 93–641, we have many concerns with some of the specific structures, relationships, and processes created by the act to fulfill those goals. In general, we believe that the respective roles of the planning agencies and each level of government should be carefully reexamined with a view toward greater State government participation in health planning and regulation.

I would like to say, Mr. Chairman, that so many of the States have already come a long way in developing their programs and getting the health planning off the ground.

Our interest with Public Law 93–641 grows not so much out of a concern that the Federal Government is attempting to supplant State health decisionmaking authority, but rather from a perception that structures and authorities created by the act tend to circumvent or bypass State health roles and thereby contribute to conflicts which are likely to prove counterproductive to the achievement of health goals.

In spite of the far-reaching effects of the health planning law, the legislative and executive branches of State government still retain major responsibility for such important health functions as licensing of health care personnel and facilities, health manpower education, regulation of health insurance, providing public health, and funding a variety of programs providing health and medical services to their citizens.

Given the range and the depth of State involvement in the health care system, and the need for greater coordination among the various components in that system, it is puzzling why Federal policy chose not to support a strong State role at the center of the human planning program.

The major focus of our proposed amendments relate to improving the structure and responsibilities created by the Federal statute, especially the functions and relationships between the new planning bodies, the health systems agencies, HSA's, and the statewide health coordinating councils, SHCC's, and the established State and local governmental authorities. We believe that the modifications we seek—very much like those sought by our counterpart organization, the National Governors Association—will go far toward improving the performance of these bodies and insuring greater, overall accountability.

In making these recommendations, Mr. Chairman, we point to what we feel has been an outstanding track record of many States in the areas of health planning and regulation.

The New York State Legislature enacted the first certificate-of-need, CON, law in 1965 and before Public Law 93–641 became law in 1974, 24 other States had CON laws in place—many of which had provisions which were much stronger than what the Federal law required. Since the health planning law was adopted, another 11 States have added CON legislation to their books, bringing the total number of States with CON programs to 36. Just last year CON legislation was adopted by Alaska, Alabama, Iowa, West Virginia, Wisconsin, and Wyoming. Significantly, the Alaska statute includes Federal facilities within its scope of coverage; the West Virginia law requires institutions to submit a long-range plan prior to submitting CON applications; and the Wisconsin statute permits decertification of specialized hospital services.

Whether or not to cover physician offices under CON has become a key issue at both the State and national level. During 1977, 15 States considered legislation which, to varying degrees, would require physicians to obtain a certificate-of-need when acquiring major office equipment or modifying their office services. Four States, Iowa, Colorado, Virginia, and Wisconsin, actually adoped such legislation. Hawaii and Minnesota already had legislation to that effect in 1975.

The 1978 legislative sessions will witness a flurry of activity with respect to certificate-of-need—both by States interested in enacting CON legislation for the first time and by States interested in modifying and strengthening requirements in existing statutes. The Ohio Legislature, for example, is presently engaged in debate over health planning legislation which would establish a CON program that would substantially exceed the minimum Federal requirements. For example, predevelopment expenditures by health care facilities and major equipment purchases by outpatient clinics would be covered by CON review. Moreover, the proposed legislation seeks to strengthen the hand of the HSA's by assuring them access to necessary information, mandating cooperation by third party payers, and providing a method of appeals from arbitrary decisions by the State agency.

The National Conference of State Legislatures has assumed a major role during the past year in assuring that information and technical assistance regarding the responsibilities of the State legislatures under Public Law 93–641 are provided to the legislatures on a timely basis. These objectives are being carried out with the financial assistance of the Bureau of Health Planning within the Department of Health, Education, and Welfare. Some of the activities of this project include: An information clearinghouse function related to State legislative initiatives with health planning and regulation; regional training seminars for key State legislators and staff to discuss implementation of regulatory programs required by 93–641 and to learn from innovations created at the State level; and the preparation of a policy manual on certificate-of-need for State legislators. It is our belief that policymakers and administrators at the State and national level have benefited substantially by this project and it

is our hope that NCSL can continue these activities in order to assure a smooth implementation of the goals and functions envisioned by the National Health Planning and Resources Development Act.

In addition to certificate-of-need programs, hospital rate review programs of one variety or another are now functioning in 27 States, while 9 States have enacted laws which require the annual review of proposed hospital budgets and the establishment of rates on a prospective basis. Moreover, hospital cost control legislation, although not enacted, was seriously considered by the following States last year: California, Hawaii, Illinois, Kansas, Maine, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Rhode Island, and West Virginia. Undoubtedly, many of these same legislatures will be reconsidering similar legislative initiatives during the 1978 sessions. And, most certainly, other States will join the debate this year.

Finally, as the Federal Government continues to study and debate the issue of national health insurance, States have begun to assume the initiative by enacting their own health insurance programs for those living within their political jurisdictions. So far, five States have enacted health insurance plans of varying scope: Hawaii and Connecticut have adopted plans which are comprehensive in scope; Rhode Island, Maine, and Minnesota have programs to insure protection against catastrophic medical expenses. Other States are currently considering similar programs. While action by individual States may not eliminate the need for Federal action, it does suggest that the States could play a significant role under a national health insurance system consistent with our tradition of cooperative federalism.

States are clearly capable and willing to make tough decisions necessary to reform our health care system. States are rapidly developing the necessary capacity for health system regulation and, therefore, they should share responsibility with the Federal Government for the development of an effective health care system. Hence, Congress and the administration should eliminate unnecessary restrictions on State governmental participation in the health planning process and encourage changes which can foster improved capacity of State governments for health planning and regulation. A couple of tangible actions Congress could take in this regard include expanding the demonstration rate review authority to all States that are willing to participate and making grants and contracts available to States wishing to experiment with decertification of hospital services and facilities.

Perhaps the most exacerbating provisions in the act from the State legislator's point of view are those which provide authority to the health systems agencies and to review and approve or disapprove each proposed use of certain Federal funds within their health service area, as well as approve or disapprove funds made available by the State—from Federal allotments to the State under such acts as the Community Mental Health Centers Act and the Alcoholism Prevention Act.

It is the responsibility of the legislative and executive branches of State government to establish program priorities and funding con-

sistent with identified needs. The ability of a local HSA to initiate a particular program, fully federally funded and absent any input from the State, may result in programs and activities that are clearly at odds with well-established priorities at the State level. Moreover, the Federal financial "pipeline" is unlikely to flow forever for such projects, leaving well-entrenched constituencies few places to turn for continued support but to the local and State governments.

Practically speaking, it is unrealistic to expect a local HSA to refuse to accept Federal project funds. And the perpetuation of an uncoordinated flow of Federal health dollars to thousands of local projects seriously undermines the States' planning responsibilities. Consequently, we recommend that HSA authority to "review and approve" State plans for formula grant funds and project grant proposals should be changed to "review and recommend" to the Governor and the appropriate State legislative committees.

As presently constituted, the HSA's are unlikely to bring about any major changes in the health care system. Instead they are more apt to insure that existing power structures will continue to wage the paramount influence in determining the shape and flow of our Nation's health care system. The assumption surrounding the makeup of the HSA governing boards and that of the SHCC was that a majority of consumers will operate as a check on provider interests. However, experience and commonsense suggest that since the consumer representatives reflect a wide variety of constituncies, many of which have not been adequately served by the health care system in the past, the more common practices will tend toward reciprocity and "back scratching" or as one analyst has succinctly put it:

> Providers and consumers will break bread together on the governing bodies, and distribute some of the crumbs to each of their members. Health planning will increasingly constitute an institutionalization and rigidification of what is, rather than a thrust towards what could be.

If, for the most part, this analysis is accurate, one is led to ask: How is the general public served by such a system? And who is it that speaks for the general public on those agencies?

We believe that only those members who are elected by the public can be said to have the public interest in mind, for it is only those elected officials who can be held accountable by the general public. However, the statute very clearly views public elected officials as just another interest group and thereby takes pains to limit their participation.

Under present governance arrangements, if the special interests of the professionals tend to dominate the local planning bodies, one's recourse is not to local or State elected officials but rather to the Federal Government. Absent public accountability and removed from day to day responsibility to any elected or appointed public official, the potential for HSA's to spend public funds or make decisions for essentially narrow purposes cannot be ignored.

In order to address some of these problems, we would offer the following amendments to the law:

The Governor should be able to appoint at least 50 percent of the members of the SHCC, with appropriate legislative ratification.

The Governor should appoint the chairperson of the SHCC, rather than having members select a chairperson from among themselves.

At least one-third of the members of governing bodies or executive committees of HSA's should be public elected officials or their designees. In deciding on representation, consideration should be given to those districts that have spending authority for health services.

Public elected officials should be exempt from the requirement that they be categorized as consumers or providers on HSA governing bodies or executive committees.

The Governor, in consultation with the appropriate State legislative committees, should have the final authority to approve or disapprove the State health plan and subsequent annual revisions of it as provided by State law.

It is somewhat fanciful to believe that decisions about the proper level and distribution of health resources can be depoliticized. Decisions which influence the allocation of limited health resources and which attempt to balance the interests of costs and benefits are fundamentally political decisions. Therefore, we are concerned as we witness the evolution of new political entities to contend with health care issues—entities that are largely independent of State and local governmental authorities and that are infused with little meaningful public accountability.

The health debate cannot avoid many tough choices—choices which frequently conflict with one another and which of necessity will be guided as much by value judgments, ethics and personal whims as by utilization projections, morbidity indices, and cost-benefit analysis. Discussions must ultimately come to terms with those "unmentionable" words in today's political arena—"tradeoffs" and "compromise." These kinds of decisions lie at the heart of the political process; their political nature cannot be disguised by the creation of non-political bodies.

The notion that somehow elected officials at the State and local levels of government tend to represent narrow, special interests is not only untrue, but also damaging to the credibility and legitimacy of representative democracy. Truly, the consumer or layman's point of view is unquestionably important on matters of public policy. But as public elected officials we have trouble with a concept that suggests we serve something less than the public interest and, therefore, need to be checked by "public-minded" consumer majorities. I need not remind the members of this committee that it is consumers that remove us if we fail to do our job. There is no substitute for that kind of accountability.

The extension of local planning authority over what traditionally have been the prerogatives of individual health care providers and provider organizations will undoubtedly be a source of continuing tension, with various subgroupings of providers and consumers adding to the potential conflicts in the planning process. Once again, we believe that elected officials ought to be viewed as a source which can help to mediate such conflicts and accommodate differences, rather than as just another affected party in the disputes.

To effect lasting changes in our health resources and delivery system we must begin to change the nature of the discussion. If we continue discussing health as is has been in the past, the professionals will clearly dominate the debate and change will be difficult at best.

Yet, if we can succeed in focusing the discussion on goals—such as, what should the health care system become, what services should be made available, what facilities and equipment are really needed, and what kinds of manpower will be required—then thoughtful nonprofessionals—including legislators—will be able to make a contribution. The capacity and willingness of State legislators and other elected officials to participate in this debate should not go untapped.

Our presence here today is to emphasize that State governments are anxious to be coworkers in the health policy arena. State governments are undergoing serious self-examination and rediscovery. They have an abundance of authority and talent which has not yet reached its full potential. Nevertheless, that authority and talent is being applied more creatively and accountably than ever before. And given the proper encouragement and deference from our counterparts at the Federal level, improvements shall be even more impressive in the future.

We are all familiar with the quote, "War is too important to be left to the Generals." Working from this adage, I would suggest that "Health is too important to be left to the providers"—or any other singular interest. The diversity and complexity of forces and actors within the health care system demands a broad-based dialog among all affected parties. Government must exercise a key role in initiating and brokering such a dialog. And, also government should serve as a major architect of tomorrow's health care system. Yet, my fear is that government is too often synonymous with national government and the legitimate concerns and interests of other levels of government within the Federal system, namely, State and local, frequently go unrecognized.

I sincerely hope that as we proceed on our respective levels of government in search of a consensus to the many vexing issues health care reform presents, this Congress will do us the honor of not viewing our organization as just another special interest group. We are most emphatically not the American Medical Association or the American Hospital Association or Blue Cross or Aetna. Although many of us within the State legislatures are physicians, nurses, insurance salesmen, and hospital trustees, as well as teachers, lawyers, and homemakers, our distinguishing mark is that each one of us—like every Member of Congress—must return every few years to a constituency that is increasingly dollar-minded and quality conscious.

Mr. Chairman, that concludes the representation of the opinions of the NCSL and I would like now to make my statement as State Representative Elaine Gordon from Florida.

Mr. Rogers. Certainly.

Miss Gordon. Mr. Chairman, members of the committee, it is an honor to be here. I appreciate very much the opportunity to appear before you and present the viewpoint of the State legislator about the National Health Planning and Resources Development Act.

I should begin by affirming my general agreement with the position statement of the National Conference of State Legislatures.

My remarks will be confined to comments of a general nature, a brief review of progress made toward implementation of this law

of the State of Florida, and several observations about possible amendments that the committee may wish to consider.

At the outset, it must be emphasized that many, if not most, of the structures mandated by Public Law 93–641 are not yet fully operational. For example, only a handful of health systems agencies have acquired fully designated status or developed even the first of several required plans. Therefore, it would seem unwise at this time to impose significant structural adjustments on the present planning apparatus because we have had insufficient experience with the existing scheme to reach firm conclusions about its respective strengths and weaknesses. To paraphrase an old saw, "If you're not sure whether it's broke, don't fix it."

The State of Florida has for many years demonstrated a strong commitment to effective health planning. Our original certificate of need law, which passed in 1972, embodies the same philosophical principles later embraced by the national health planning law; namely, emphasis upon broadly based community participation in decisions that affect the organization, access and cost of health care.

At present, Florida has nine conditionally designated health systems agencies each of which is a nonprofit structure. The State health planning and development agency is our department of health and rehabilitative services. Two of our HSA's have applications pending for fully designated status. All nine of our HSA's may be fully designated by April of this year.

Because we had several years of experience with coordinated State and local health planning, the transition from the prior system to the structures mandated by Public Law 93–641 was a relatively smooth one in our State. It so happened that in 1975 our legislature reorganized our human services department and provided service districts for that department which were, with the exception of one county, coterminous with the health service areas designated under the Federal health planning law. Since 1975, the county which was not in compliance with this design has been shifted so that our human service districts are now geographically in complete alinement with those of the health systems agencies. It was the intent of the legislature by so arranging these districts to insure the maximum organizational coordination between HSA's and service delivery districts. This has proved to be a most agreeable arrangement and has significantly facilitated transfer of information between HSA's and the State agency.

In 1977, the Florida Legislature amended its certificate of need law for the specific purpose of conforming to the requirements dictated by Federal law and rules. At the moment, our State health planning and development agency officials are meeting with the HEW personnel in Atlanta to determine whether we are in compliance.

This brings me to an important point concerning proposed changes in the Federal health planning law. While Florida wishes to be in compliance with certificate-of-need requirements, and indeed has a law which significantly exceeds Federal minimum standards, changes in Federal law and rules in this sensitive area place State legislatures in an untenable position. For each time that this law or rules adopted

under it are changed in Washington, the States must in turn seek to make modifications in their own certificate-of-need programs. In most instances, this involves the difficult process of amending a controversial law through State legislative action. I am not confident that the Florida Legislature, which meets only 2 months out of the year, will be of a mind to annually respond to such changes.

Having touched upon some of the history of Florida's implementation of the Federal law and the years preceding it, I would like now to move on to a discussion of possible changes that the committee may wish to consider. Most of these changes will not require a major revision of present law. They may, however, help to clarify and reduce the complexity of relationships under the present structure.

I would begin by suggesting that the committee revisit the powers conferred by law upon the State Health Coordinating Council. I am particularly interested in seeing to it that some mechanism is provided whereby review of State health plans approved by the Council is afforded to either the executive or legislative branches of State government or possibly both. These plans have a vital impact upon the organization of the delivery of health services in the States and, therefore, I feel that State government should be a part to their development and approval. I further believe that approval authority with respect to certain Federal grant money for statewide programs that now rests with the State Health Coordinating Council would be more appropriately left to the Governor of the State.

When title XVI of the Federal Health Planning Law replaced the Hill-Burton program, it was my hope that funds appropriated under this title would be available for programs providing alternatives to traditional institutional care. Unfortunately appropriations under this title have not been forthcoming.

In Florida, as most of you know, we are privileged to have a higher percentage of people over 60 years of age then any other State. In Dade County, greater Miami area, alone there are more residents 60 years and older than comparable age groups in 16 other States combined. Unfortunately, traditional medical practice has not been responsive to the unique needs of this age group.

Because as a Nation, our median age will continue to inch upward in the foreseeable future, it becomes apparent that Florida is now having to deal with problems that the rest of the country will face in years to come, and in fact, new systems of health care for the elderly have begun to emerge.

Florida in particular is a fertile testing ground for the rest of the Nation because due to the necessity of providing a vast array of multi-faceted services to a distinct elderly population, new specialties of health care delivery and new training and education programs have been developed. Florida is now a resource for the rest of the Nation of creative programing for the elderly. We have the capability, the talent and the expertise to share.

With financial assistance through adequate funding of title XVI, it would be possible to substantially advance these innovative efforts already underway in Florida. In short, although efforts to rationalize the present system through effective health planning are

essential, I believe that making available alternatives to the existing treatment systems may be the most lasting and significant contribution that will result from this law.

With respect to the administration of the program by HEW, there have been certain shortcomings. There was, of course, the controversy surrounding the guidelines for planning. Equally important, but perhaps less visible, has been the slow pace at which technical assistance has been made available to State and local agencies. There have been improvements in this regard over the past year, however, much more could be done. This is a difficult and sensitive program to implement at the local level. Every effort should be made to insure that HSA's and State health planning agencies are not forced to muddle through but instead have available the best possible technical support from Washington and the regions.

In closing, it is my hope that the Congress will strongly recommit itself to the laudable objectives set forth in title XV of the Health Planning and Resources Development Act. I believe some attention to structural issues is indicated but urge you not to undertake a fundamental rewrite of the law; because any such re-write would only serve to further the cause of health planning opponents by keeping the system in a state of imbalance.

Thank you, again, for the privilege of making my presentation on this important issue. And special thanks to Representative Rogers, my fellow Floridian.

Mr. ROGERS. Thank you, Representative Gordon, for a very helpful, constructive statement. The committee will carefully go over your suggestions.

Miss GORDON. Thank you.

Mr. ROGERS. I know the experience you have had in Florida gives you the expertise to make these statements which are helpful.

Representative Tallon.

STATEMENT OF HON. JAMES R. TALLON, JR.

Mr. TALLON. Mr. Chairman and members of the Subcommittee on Health and the Environment, I am James R. Tallon, Jr., a member of the New York State Assembly and Chairman of the Assembly's Program Subcommittee on Health Costs and Financing. Prior to my election in 1974, I served as executive director of the NY-Penn Health Planning Council, an areawide 314b Comprehensive Health Planning Agency in Binghamton, N.Y., as a member of the board of directors of the American Association for Comprehensive Health Planning in 1973 and 1974, and am currently a member of the board of directors of the NY-Penn Health Systems Agency.

My brief personal comments here today hopefully offer the perspective of a health planner, a legislator, and a New Yorker on the various suggested changes in the National Health Planning and Development Act of 1974 including the proposals contained in H.R. 10460.

Mr. Chairman, your remarks in the Congressional Record of January 19 reaffirm your belief in the soundness of the basic health planning structure created by Pub.L. 93–641. I endorse that sentiment.

Since the discussions of 1973 and 1974 which led to Pub.L. 93–641, there has developed greater national recognition of the challenge of cost containment within the health care system. Because of the unique fiscal pressures experienced by the State of New York and several of its localities in 1975 and 1976, and because of the relatively high public sector share in supporting New York State's $15 billion health industry, I believe we have learned valuable lessons which ought to be considered in the process of amending the Health Planning and Development Act.

New York has gone beyond placing limits on the growth of the health care system. Our experiences have dealt directly with shrinkage in the number and size of institutions. The proposed amendments anticipate the "discontinuance of duplicative or unneeded facilities and services and facilities" being accepted as an explicit national health priority.

We have had success in the elimination over the past 2 years of almost 30 hospitals and a net reduction of almost 2,500 beds. We have seen the elimination of unnecessary maternity services and the regionalization of specialized services.

However, we have learned, in my opinion, much about the substance and process of a "shrinkage" policy. We have learned that substandard facilities can be closed. We have learned that closure of facilities on the premise of excess need, however, will raise complicated legal questions concerning property rights, planning methodology questions concerning the financial and medical impact of forced consolidation, and community based political challenges when the loss of a specific services is offset by benetfis felt only indirectly by the people being served. You have heard many of these reactions to the publication of national health planning guidelines.

It has become clear in New York that successful implementation of further shrinkage in the number and size of institutions requires careful review of the validity of our planning methodology; specific attention to the incentives necessary to build public support, whether through the availability of alternative improvements in service or direct consumer cost reductions; and substantial local authority in the shrinkage decision to prevent the characterization of the decision to reduce services as an external politial threat.

The recent New York experience also suggests caution in the implementation of new conceptual approaches to planning. An overall limit on capital expenditures is appealing to those who would measure relative need. It is, nevertheless, a new tool and caution is advised in its implementation. The fragile political structure of health planning can afford few public mistakes.

The proposals contained in H.R. 10460 envision some degree of increased State responsibility in the health planning and development process. While some may argue for even greater State authority over planning decisions, careful consideration should be given to extensions of authority only to a State executive or executive dominated agency. The long-term goals of the National Health Planning and Development Act require the broadest possible support if they are to be reached. As a legislator, even with a high degree of per-

sonal involvement, the health planning process in my State has seemed distant, obscure, erratic, and occasionally confusing. Provisions for State legislative involvement in the various boards and structures created at both the State and regional levels, and in the process of determining needs and priorities for the respective States can only strengthen the narrow base of the present movement.

Several proposals deserve specific endorsement.

The extension of certificate-of-need decisions to major equipment purchases regardless of setting is a necessary step.

The improvement of HSA funding, especially in the case of my own personal experience with a small, under 500,000, bi-State agency, is essential.

Greater coordination of health planning and rate review is clearly required. Control of capital expenditures, however large, will remain at best an indirect method of cost containment.

Mr. Chairman, the tone of the recommendations in H.R. 10460 and of your own statements indicate the evolutionary nature of the planning process. As we take the next steps, let us focus on the information and procedures necessary to develop and maintain broad public support in reaching our national health goals.

Mr. Chairman, just two brief notes in addition to the testimony to call attention to section 209 of the bill in which we talk about the additional involvement of the locally elected officials on the HSA boards.

I would hope we would be careful in writing the language of that section so as not to arbitrarily limit that public sector involvement to local officials. State legislators like myself and indeed, Mr. Chairman, Members of Congress or their designees may find themselves appropriate members of HSA boards and in that section let us not focus too narrowly on the local representation when we talk simultaneously about public officials.

Second, Mr. Chairman, in section 223 of the bill we talk about the issue of the composition of the statewide health coordinating council, we talk about changing the current provision of two members per HSA. We try to relate in that section of the bill some relationship of the size of population being served. In that section, Mr. Chairman, I hope you would take into account the specific experience of New York where the ratio between the largest and the smallest agency is 20 to 1. If that were the case, we would have to take into account the overall size of the statewide health coordinating council. I would hope we would have some flexibility in the final selection.

Thank you very much.

Mr. Rogers. Thank you, Mr. Tallon, for an excellent statement. We appreciate it.

Mr. Traylor.

STATEMENT OF FRANK TRAYLOR, M.D.

Dr. Traylor. Mr. Chairman, I am Frank Traylor, a physician of the Diplomat Board of Surgery serving in the Colorado State House of Representatives. As the only physician in this body it has fallen

to me to attempt to reconcile the State certificate-of-need program with the Federal requirements. This is no easy task, I can assure you. I will attempt to be brief and nonrepetitive.

I would agree with the need for elected officials on HSA's but hope that they would not be placed thereon diminishing the number of physicians on the HSA board. The part that we have not dealt with today in your amendments would have to do with the grants for hospital rate review. As the law is presently written, the State Planning & Health Development Agency is the designated one who will have to do the rate review to get the Federal funds. In Colorado the hospital association and the legislature of the State government all felt that rate review should be done by a separate agency, not the SHPDA, and so I would hope that the law could be amended to say that if the rate review mechanism complied with the Secretary's mandates that it would be available or could be qualified for grants.

I would like to make a few general remarks as an individual concerning the certificate-of-need program. Colorado has had one since 1973. It was not very successful to begin with because a number of projects were grandfathered in. In addition, public pressure was not very strong and the Health Facility Advisory Council, as that group is called, that passes on certificate-of-need did not have much pressure on it.

In the last year there have been a number of projects turned down and review has been much more stringent, so I would hope that before you tighten the screws down federally as to what the agencies are doing in each State, you can possibly give each one a little more time. I think you will realize that they are much more effective than they were in the past. It does take several years to get going because of the grandfathering.

There are some areas, though, presently I think which are pernicious. First of all, all institutional health services have to be reviewed, all new institutional health services. This could include anything. In a field like medicine this is extremely stifling and it would stop, I think, all new advances or at least slow them down if you have to get a new certificate-of-need for everything. I see in your bill that this will be changed.

The regulations specify that the certificate-of-need agency if it does not make a decision the certificate is automatically discarded or refused. This makes an easy out for an agency and I think is not giving due process to the applicant so I would hope that that would be changed.

There are some things that I think you should be aware of. A certificate-of-need really does distort the market mechanism. For example, in Colorado Dr. Foley who testified this morning was our head of the social service department. He had a maximum that could be paid as a daily rate in a nursing home, $21. In Denver we have a few extra beds, and there are some good nursing homes and some bad nursing homes. The bad ones have empty beds and the good ones have a waiting list. There are vacancies. If two or three good nursing homes opened in Denver, the bad ones would go out of business. Instead the State now is clamboring for a bill which would

regulate poor nursing homes. We really don't need that bill if the marketplace would punish the bad ones and put them out of business. As far as the Colorado experience is concerned, it is my experience that the certificate-of-need distorts the market and bad nursing homes stay in business.

One other comment about distortion. I believe that HMO's do need possibly special consideration but I would hope that if you do modify the law or amend it that you would not give them a break at the expense of the Blue Cross or patients who pay their own way.

In other words, if an HMO can rent beds in a hospital which is half full, it would seem to me that granting them the ability to start a new hospital on their own and just empty out existing beds would be deleterious and counterproductive .

Finally, decertification. It would seem to me that decertification is an extremely sensitive political area and that the best way to do this is through a rate review mechanism in which the rate review board assures everyone that they pay for what they get.

In other words, the pharmacy should not subsidize a half-full maternity unit or the X-ray department should not furnish money to another part of the hospital which is not making money. So if the rates are actually set on the service provided and the accounting procedures are established so that each unit-cost center in a hospital pays its own way, it will soon be apparent that costs of $300 or $400 a day would be applicable on a ward that is half full and the hospital will be forced to close that part which is underutilized.

I wish you success in your deliberations on this bill and appreciate appearing before you.

Mr. Rogers. Thank you for the suggestions you have made and the points you have raised.

Would you suggest an accounting system that is consistent for all hospitals to get to the problem of making sure each division of the hospital pays its own way?

Dr. Traylor. Yes. We passed legislation creating a rate review commission last year and that was one of the requirements. Uniform accounting, uniform designation of cost centers, and so on.

Mr. Rogers. And you think that has worked out?

Dr. Traylor. Well, it has just started 6 or 8 months ago. It is similar to Washington, Maryland, and other States.

Mr. Rogers. Representative Gordon, you thought it might be a good idea to have some funds to use to demonstrate decertification before we move into it in a heavy way to let some of the States experiment with that.

Miss Gordon. Well, we have some programs going now. We have been designated five areas of our State as experiments in the Community Care for the Elderly Act but even aside from that private agencies have been getting into experimentation out of necessity. There are certain things that they have to do.

For instance, we are only one of two States nationwide that are doing "Meals on Wheels" with frozen meals and it is working out beautifully. If we could develop those programs and be able to demonstrate that down the road, it is going to be helpful for the rest of the country.

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We also had a bill in the legislature which we funded through title XVI, as a matter of fact, where elderly could be cared for within the home, setting by their own relatives with a small subsidy. Most of the time many, many of the elderly could easily and in fact more desirably be at home except for the fact that the family members simply can't handle the expense. So with a subsidy to the family to care for that person, aside from the humanitarian aspects of it, it is cost-effective and could keep elderly out of institutional settings.

I think that we have come a long way in this country in developing ways to keep people alive and have done little to improve the quality of that life once we have extended it for them. I think that Florida could be the testing group and certainly has already developed the experience that ought to be the resource.

Mr. ROGERS. Thank you so much.

Representative Tallon, I presume you would say we should not make any significant changes in the law or in the structure.

Mr. TALLON. I think, Mr. Chairman, the basic concepts of the law are valid and what we are talking about are changes in the relative levels of power within the system. I think it is reasonable as a State representative that I can endorse the proposal for some greater State participation in some ways that have been pointed out in the bill but it strikes me, Mr. Chairman, that we really have working out there in the field only about 2 years of experience from the time we have gotten the agencies going. We are dealing with an enormously complex industry with a particularly complex economic structure, a combination of public and private involvement, perhaps one of the most complex in all society. We put in place a series of agencies made up of people who are, by and large, working in good faith and they are, by and large, supported by professionals of developing skill. It seems appropriate to keep that system in place, to allow it to proceed forward, and in that sense monitor its performance in the years ahead.

Mr. ROGERS. Thank you so much.

Dr. Carter, do you have any questions?

Mr. CARTER. Thank you, Mr. Chairman.

Representative Tallon, you have already gone through the decertification in New York.

Mr. TALLON. Yes, sir.

Mr. CARTER. And you had 2,000 excess beds which you closed and 30 hospitals. That would have saved you how much money in the State? Do your books reflect that saving?

Mr. TALLON. I don't have that number, Mr. Carter. It is in the millions of dollars, of course.

Mr. CARTER. It is interesting to note that.

Now, technically, according to what we have been told, that should have saved the State of New York $60 million each year since those beds were closed.

Mr. TALLON. Yes.

Mr. CARTER. I hope that it did. I hope on your balance sheet that that change was reflected.

Mr. TALLON. It is a change that we welcome, Dr. Carter.

Mr. CARTER. From your budget of $15 billion—I believe that is what you spend there—I think it would not be much of a change but

at least $60 million is a pretty good sum of money, a large sum of money.

I was interested in what you were saying about nursing homes. In some areas doctors have given orders that patients not go to one particular home, to the neighborhood home, because of poor conditions in those homes. Yet those neighborhood homes are not allowed improvements because there are vacancies in nursing homes in the adjacent counties. Is that something along the line of what you were saying, Doctor?

Dr. TRAYLOR. No. Actually the problem arises that we have excess beds but some of the nursing homes that are inferior are half full whereas the good nursing homes have tremendous waiting lists and we cannot build new nursing homes because the certificate-of-need won't be granted. One or two good nursing homes would, in my opinion, put the bad ones out of business.

Mr. CARTER. Yes, it seems so to me.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much. We are grateful to you for being here and your testimony has been most helpful.

Miss GORDON. Thank you.

Mr. ROGERS. The last witness today is Cooper L. Parker, director of the Iowa State Health Planning Agency, Des Moines, Iowa.

We welcome you to the committee, Mr. Parker.

STATEMENT OF COOPER L. PARKER, DIRECTOR, IOWA STATE HEALTH PLANNING AGENCY

Mr. PARKER. I would like to begin with a brief observation on the testimony I have heard so far today.

Mr. ROGERS. Certainly.

Mr. PARKER. I would like, if possible, to attempt to dispel the myth that by removing elected public officials from the process that we have taken politics out of health. We have not. If there is any doubt in anyone's mind that the politics of health is important, I would simply refer the doubter to the recent turmoil on the policy planning guidelines.

I listened with great interest in Iowa to the public and private statements of the HSA directors and the politicians and I was struck, Mr. Chairman, as I perceive the committee would be at the similarity between the two. Now there are cynics in Iowa—yes, we have them in Iowa, too—who would offer as a partial explanation for that the fact that the Iowa Hospital Association is prominently represented on the HSA board and the subarea councils but I would leave that to others to make a determination.

I would also, in keeping with that, point to a recent article which appeared, I believe it was last week in the Des Moines Register and pointed to the fact that the Iowa HSA has had several elections of board members since it came on the scene but that as yet no new persons have been elected to the board, which brought those cynics out of the woodwork again to wonder if it is possible that the role of the HSA board member is beginning to be perceived by them as that of getting reelected.

The point, Mr. Chairman, is that by removing elected public officials from the process we have not removed politics from health. The politics of health is as sophisticated and as tough as street politics ever thought about being and we need to remember that.

Briefly, Mr. Chairman, I am here speaking today on behalf of the State Health Planning and Development Agency directors of Department of Health, Education, and Welfare region VII, which includes the States of Iowa, Kansas, Missouri, and Nebraska; region VIII which includes Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming; as well as the States of Wisconsin, Minnesota, and New Mexico.

We are here to encourage support for three amendments to Public Law 93–641 which will increase the role of the States in the health planning process, and to tell you why we believe this to be necessary to the success of the Health Planning Act.

Before going to that, however, I have been asked by my counterparts in Kansas, Missouri, Nebraska, North Dakota, Montana, Wisconsin, Minnesota, and New Mexico to comment to you about the recent uproar over the proposed national planning guidelines issued last September. You may recall that my own State of Iowa was particularly active in the public comment on those guidelines. We were mightily—and vocally—concerned about two things:

One, that groups which should have been consulted in the preparation of the guidelines were ignored and; two, that the rural health care facilities were threatened by the guidelines.

I want to emphasize that, although most of the objections to the guidelines came from States classified as rural, no one should be misled by that to think that the guidelines as published in September posed a danger only to rural States. It is more accurate to say that they threatened rural areas. I serve on a committee to advise the human resources committee of the National Conference of State Legislatures, and at a meeting of that body in November, I listened with great interest as legislators from rural areas of two of our most urban States voiced the same criticisms of the guidelines that we in Iowa had.

I want today to tell you that the State agencies of Iowa, Kansas, Nebraska, Missouri, North Dakota, Montana, Wisconsin, Minnesota, and New Mexico have reviewed the revised guidelines and can say to you that they provide the relief and flexibility which we sought. We are grateful that the Department proved attentive to the voice of the people who live in rural areas. Utah, South Dakota, New Mexico, and Colorado had only just received the revised guidelines and had not had an opportunity to review them. We know that in Iowa, for instance, we have more hospital beds than we need. We are aware of the necessity to shrink the size of the health care delivery system. We were asking that we be permitted to accomplish that task, however, without jeopardizing access to care in rural areas. The Secretary and the Department were responsive to that concern, and we are pleased. Moreover, we see the decision of the Secretary to open the revised guidelines to further public comment as highly conciliatory on his part and we are of the opinion that it will go far to gain support for the guidelines when they do appear in their final form.

And now to the specific amendments to which we want to give our support. They are:

One: The amendment to permit the Governors appointing authority over the chairperson of the statewide health coordinating council, using whatever appointment mechanisms in the States.

Two: The amendment to require the Governor to approve the State health plan before it becomes final.

Three: The amendment to permit the Governor or the appropriate State agency to override health systems agency disapproval of Federal formula grant funds.

I must tell you that two of our number, Wisconsin and Missouri, are not unqualified in their support of this last amendment. They do, however, want it understood that they agree in principle with it.

All three of these amendments, taken together, would strengthen the part to be played by the States in planning for the delivery of health services and in formulating the policies necessary to implement the planning. Consequently, I will not spend time arguing the particular merits of each amendment, since it is their cumulative effect which we support. I will rather direct the remainder of my remarks to our reasons for supporting an expanded role for the elected public officials within the States.

In the first place, State government, in our opinion, has a record of accomplishment in the field which significantly predates Federal initiatives. It is important, we think, to note that the States, not Congress, conceived of the idea of certificate-of-need as a step toward cost containment. In 1964, a commission appointed by the Governor of New York began work which resulted in the country's first certificate-of-need legislation, in 1965. Between 1965 and 1972, when Congress authorized capital expenditures review under section 1122, 15 States had passed such legislation. Between 1972 and 1975 an additional 11 States had enacted CON laws. Six States, including Iowa, have extended review of capital expenditures to physicians' offices. In addition, according to recently collected, but as yet unpublished data, nine States are considering legislation which require review of capital expenditures in excess of $100,000, as opposed to the Federal requirement of $150,000. Can it be that the States have the flexibility the Congress may lack to meet the threat of the $95,000 CAT scanner? Also, 14 States are considering CON legislation which would extend coverages, in excess of Federal requirements, to such facilities as TB, psychiatric, home health, and kidney disease.

We in the States often hear that we must be bypassed because elected public officials will not make the hard decisions necessary to shrink the system. The facts I have just submitted to the subcommittee seems to argue against such an assertion. We urge this subcommittee to recognize it for the myth that it is. One can hardly listen to a recitation of the States' initiatives which both predate and exceed Federal initiatives and still try to cut with such an old saw.

Furthermore, to the best of my knowledge, no one is touting certificate-of-need as the be-all and end-all of health care cost containment, and the jury is still out on whether it is helpful in this regard at all. Therefore, we might ask what the States are doing on their own initiative to contain costs, outside of what the Federal Govern-

ment requires. We hear that certificate-of-need coupled with rate regulation can be an effective cost-containment measure. You may find it interesting to know that as of January 1977, according to a survey conducted for the American Hospital Association, 25 States had in place rate regulation mechanisms of some sort. Now, one may argue how thoroughgoing each of these might be. However, it hardly seems fair for the Congress to exclude the States from the Health Planning Act bectause of footdragging when fully half of them have moved toward a position which the Congress is only contemplating.

A significant State role is necessary to insure the success of the Health Planning Act itself. A recent article in the National Journal talks about "HSA's, Power and Politics." I quote from that article:

> Depending on local circumstances, HSA's hitch their wagons to elements of the local power structure, hoping to influence the health system by sharing goals with other interests.
>
> In Akron, Ohio, for example, the Health Systems Agency of Summit-Portage County relies heavily on the influence wielded by local industry. Richard M. Marin, health service industry relations manager of Goodyear Tire and Rubber Company, is president of the HSA.
>
> Martin has effectively employed the backing of Goodyear's chairman * * *
>
> In Miami, Florida, the picture is totally different * * * the Health Systems Agency has relied heavily on support from * * * the city's two major newspapers.

Not every community has a major industry, or even a newspaper. But there are two entities which impact every community in America: A State legislature and a Governor. The people who have authorized me to make this statement for us all today have only the greatest enthusiasm for the active involvement of all elements of the community in health planning and policy development. But we urge you to include those actors—Governors and legislatures—without whose participation the house of cards comes down.

I recently heard a health planner defend the exclusion of elected public officials by saying, "The health cost problem didn't arise overnight. Costs have risen steadily over the last decade and politicians haven't stopped it." Neither, I would urge, have consumers, doctors, or hospitals. "Politicans" alone, surely, are not responsible for the rising costs. Indeed, as I have argued earlier, they have, at least since 1965, been attempting solutions. One could as easily point the finger of blame, and some do, at hospitals, doctors and other health care providers. But, Mr. Chairman, are they systematically excluded from the act? No, indeed. Instead, the composition formulae of health systems agency boards and statewide health coordinating councils jealously insure their inclusion. But State and local governments are excluded. It is time now to rectify this particular injustice.

Finally, it is to elected public officials to whom eventually the planners must turn to convert planning into policy. The planning process can point to the necessity of certifying need before expanding facilities and all can marvel at the process, and the methodology and the firm basis for such a recommendation. But until a constitutional majority of the State legislature passes a bill, and the Governor signs it, you never will have certificate-of-need. And how long do you think it will take planning mechanisms to wither without policy support? A review of the goals and objectives—and when will we realize that those terms are synonymous—of the health systems plan of one of

Iowa's health systems agency reveals that over 70 percent of them will require action by the Governor or the legislature or both if they are to be achieved.

The fact that State government has been responsive to people's needs even though they have been excluded from the planning and policy development process is clearly documented. We are saying that the arguments most often advanced to support that exclusion are fallacious and that to continue it will not be in the best interests of the objectives of the Health Planning Act which we support.

To conclude, Mr. Chairman, the fact that we have spoken only to these three amendments does not mean that we do not support the other amendments endorsed by the National Governors Association, or any other group. It is only that these are three very important changes we would like to see made. I have been asked to remind you that the first two amendments we are addressing today have also received the support of the National Conference of State Legislatures.

Thank you, Mr. Chairman, for your patience and your forebearance.

Mr. ROGERS. Thank you, Mr. Parker. We appreciate your help.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

On cost containment you state that you have predated certain Federal initiatives and therefore you believe that you are capable of going ahead with your plan without Federal direction. All you want is the Federal funding, is that correct?

Mr. PARKER. If I am understanding you to say do we feel that we are competent to do planning for the States, I would say yes. What I am saying is that I believe the State government should have a larger role in the planning process for the reasons that I have enunciated that the State government has to make some important determinations.

Mr. CARTER. Every citizen of an HSA is a member of your State.

Mr. PARKER. That is true.

Mr. CARTER. All the state health planning, SHPDA—all of that is part of the State. What we are doing is giving you the money and some directions but you want it without any direction, is that correct?

Mr. PARKER. No; that is certainly not what I am saying, Dr. Carter.

Mr. CARTER. Yes, sir.

Mr. PARKER. I have been misunderstood if that is the perception.

Mr. CARTER. Over the years you have been given the proper direction. If we tax the people and supply you with these funds, then we have the duty to see that they are wisely spent.

Thank you.

Mr. PARKER. I agree with that, Dr. Carter. I would simply state, if I may, Mr. Chairman, that what I am saying is not that we want no Federal guidelines but that the way the law is written right now I would submit the State legislature has to make determination on what kind of certificate-of-need law will be enacted. Now there are certificate-of-need laws and there are certificate-of-need laws. I happen to favor very stringent certificate-of-need laws. In Iowa I served on the staff of the legislative committee last year that handled certificate-of-

need and we have a good certificate-of-need law but what I am saying is that since State legislatures and Governors are called into the process it is better to call them in at the beginning of the process rather than at the end.

Mr. CARTER. Thank you.

Mr. ROGERS. Thank you very much.

Mr. PARKER. Thank you very much, Mr. Chairman.

Mr. ROGERS. We appreciate your testimony.

That concludes the hearing for today. The committee will stand adjourned until 10 o'clock tomorrow morning.

[Whereupon, at 3:48 p.m., the subcommittee adjourned to reconvene at 10 a.m., January 31, 1978.]

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

TUESDAY, JANUARY 31, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, at 10 a.m., pursuant to notice, in room 2415, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing hearings on Health Planning and Resources Development Amendments, 1978.

First off, I think Mr. Florio had a comment or two.

Mr. FLORIO. Mr. Chairman, thank you very much.

I would just like to take this opportunity to recognize the presence here of a very important labor leader in my area, Mr. Harry Benn of the International Ladies' Garment Workers Union, who has a delegation here. This particular union has been very active in the forefront of health care legislation, so I am pleased to welcome them, and to acknowledge their cooperation in the past.

Mr. ROGERS. We are pleased to have you here at the committee. I am sorry we do not have enough chairs, but we are delighted to have you here, particularly since you are from the district of our distinguished member who has been so active and helpful in writing health legislation to improve the health of the American people.

Our first witness this morning will be Mrs. Jacqueline B. Hanson, who is treasurer of the American Health Planning Association and chairman of the board of Mid-America Health Systems Agency; and Mr. Stanley J. Matek, who is the executive director of the Orange County Health Planning Council in California.

We welcome you to the committee. Your statements will be made a part of the record, without objection, and you may proceed as you desire.

Mrs. Hanson.

STATEMENT OF JACQUELINE B. HANSON, TREASURER, AMERICAN HEALTH PLANNING ASSOCIATION, AND STANLEY J. MATEK

Ms. HANSON. Good morning, Mr. Chairman.

My testimony, as you commented, has been distributed for inclusion in the record [see p. 215].

Mr. Chairman and members of the committee, as Congressman Rogers said, I am Jacqueline Hanson. I am a consumer and have been, for 2 years, president of Mid-America Health Systems Agency's board of directors, a bistate health systems agency in Kansas and Missouri; and I am treasurer of the American Health Planning Association.

I am here this morning testifying for the Health Planning Association, a national organization which, as you may know, represents a wide variety of consumer and provider board members of planning agencies, as well as professional planners and the whole spectrum of the health planning world.

We have a tremendous diversity in membership and, for those reasons, our particular concern is to promote the health planning framework which permits the proper interaction among all parts of that framework.

We have studied H.R. 10460 closely, and we are convinced that this proposal contains a number of new initiatives to integrate correctly the concerns of local planning agencies with the State and those at the Federal level.

Mr. Chairman, you and your staff, are to be congratulated for addressing the major concerns of board members and health planners and for introducing a legislative proposal which, if adopted, could improve the health planning process without significantly disrupting it.

We feel that you have managed to not accommodate any specific interest to the exclusion of others; an accommodation, we feel, would ultimately weaken the process.

Health planning faces a time of testing. Many of the planning entities, which were constituted under Public Law 92–641, have just now completed the substantive tasks of health systems plan development and are beginning the implementation of project review, resource development, and cost containment.

We are very pleased that the changes which are contained within H.R. 10460, are ways of more fully implementing the planning process and the interactions therein.

We are pleased to see increased responsibilities for board members, HSA's, SHPDA's and SHCC's around the country. H.R. 10460 offers proposals to clarify and make more specific the agenda for planners and for the coordination of priorities at each step of the planning process.

We also are very pleased to note that the bill permits that these responsibilities be adequately funded.

Mr. Chairman, you know, as we do, that one of the principal blocks to effective health planning has been a lack of clarity regarding the roles and functions of the planning agencies themselves. An HSA cannot establish its credibility in a community unless the people in that community know what an HSA really represents, and whether or not an HSA is likely to endure.

The American Health Planning Association believes that the Congress created our agencies to deal with controversial issues of resource development, cost control, and the improved efficiency of health services. To do this effectively, we need the support of Congress. We need its critical scrutiny and we need its thoughtful scrutiny.

If H.R. 10460 is passed, it makes it clear that neither the Federal Government nor the State, can override local determinations without due process. We feel comfortable that the HSA's will continue to grow in the proper manner.

There are several sections of the legislation which I would like to mention. I will then turn over the balance of the time to Mr. Matek.

In section 203, which speaks to redesignation of health service areas, there is some language there we are confused and a little unhappy about. A sentence that begins, "Or a change in the boundaries of such areas would result in a health service area which better meets the requirements of such subsection." We find that a difficult one to implement, for how can you compare the actual HSA boundaries against a proposed boundary to find out which would be the most effective.

In our testimony, in some detail, we have outlined an alternative to that language and suggest adding to the requirements of section 1511 an effectiveness standard, the language of which is included in our testimony.

We also support the intent of section 205, which allows the Secretary to put limits on the functions of fully designated agencies. However, this optional arrangement, we feel, could potentially cause misunderstandings. Many of the HSA governing bodies, and those with whom we have contact, are concerned that a particular agreement could be too limiting and also possibly object to a top-down type of priority. We would suggest that limitation of HSA functions might be handled less ambiguously by returning HSA's to conditionally designated status.

Section 206(b) encompasses the extraordinary travel and allowances that could be necessary in areas where you have large, rural geographic situations, HSA's which serve several SMSA's, or HSA's located in more than one State, such as the situation in which I serve, where we have two SHCC's, two SHPDA's, two Governors, and duplicate our efforts.

We think this is a very wise thing to have included, though we have found, in a quick survey, that these extraordinary expenses have rarely exceeded 10 percent, and often are as low as 3 percent of the agency budget.

There is also a comment about the section dealing with exceptions to residency requirements. As you recall, it says in the legislation that a board member could serve on a Board of Directors from the location of his place of business as opposed to the place of his home.

First: We suggest that this should be implemented for consumers and for providers, and not just for providers, although we understand the intent of why it was just included for providers.

Second: We have concern for the entire section, in that it could, by implication and in actual practice, possibly change the balance of an HSA. That amendment could be counterproductive and perhaps would require some more examination.

In section 209, we are pleased to see that it is going to be possible to allow strong supporters of planning to be members of governing bodies without a 12-month delay following their leaving a provider position. We think that is a very healthy step. It should help insure broader participation in the health planning process.

However, we do feel that the requirements of section 210 could be phased in as part of the normal board turnover and attrition process.

That way the planning agencies could continue with their work without a total disruption for reorganization during these very busy times, and we could still achieve full public accountability at the local level over a carefully phased-in time.

Section 223 deals with SHCC composition and is one that has caused us some concern.

First of all, it is going to be difficult to implement without a severe disruption of the planning process. If one accepts the role of the SHCC in coordinating planning, you need to test out the function of the SHCC with its present composition intact. I do not believe that there has been an opportunity for that to be done.

You need to weigh the size and functional decisionmaking capacity of a large SHCC.

The purpose of a SHCC, we feel, is to reflect a statewide consensus, not to allow the concerns of one particular area to outweigh those of another.

We think the present composition would not necessarily lead to underrepresentation in urban areas in the development of a State health plan.

In addition, the formula suggested in section 223 is ambiguous with respect to the size of an HSA which should be considered for minimal representation. This formula may thus be inequitable in differentiating between HSA's of different populations which have minimum representatives.

I will now turn this over to Mr. Matek for his comments and then I would be happy to answer questions.

Mr. Matek.

Mr. Rogers. Thank you for summarizing your statement and highlighting the concerns that you have.

Mr. Matek.

STATEMENT OF STANLEY J. MATEK

Mr. Matek. Thank you, Mr. Chairman.

I would like to begin, if I may, by thanking those Members of Congress and staff of DHEW who were involved in the process of improving the national health planning guidelines, making them more flexible and reasonable. We appreciate the contributions of Dr. Henry Foley and Mr. Califano, the Members of Congress and particularly the members of this committee. We have had letters from Congressman Satterfield on the guidelines and we have heard also from your office, Mr. Chairman.

It was extremely important for us to see the flexibility principle clarified in those guidelines. One of the reasons we like H.R. 10460 as it has been introduced is that it preserves, clarifies, and solidifies the balance in operating relationships between Federal, State, and local elements in the health planning system.

That is a balance which we think is absolutely essential. We must continue to prevent any one of the partners in this system from bullying others, because, if people at higher levels in the system can bully

those lower down, then there is no reason to have volunteers involved at the local level. And without those local volunteers, the whole premise of checks and balances and accountability in Public Law 93–641 falls apart.

Your new bill maintains a very careful balance among these forces, and to us that is its major virtue. We feel that if we are going to have health planning work, that balance must be maintained in its careful and delicate calibration.

HSA's do not want to dictate everything in this system, but neither do we want to be dictated to. We want to be accountable for what we do and why we do it, and we want to help make the Federal and State bureaucracies accountable for the way that they behave. That is the basic purpose behind the points we are making in our testimony today, and the purpose of the work we do as HSA's.

I would like to register the strongest possible support for the language in your bill which makes it a priority to discontinue duplicative or unneeded services or facilities. We ask you, please, to maintain maximum emphasis on the concept of appropriateness review because, without it there is no substantial leverage for change in the local health care system.

Our health plans talk about goals and priorities, but it is appropriateness review more than anything else that will make things actually happen. The certificate-of-need program alone only freezes the system the way we have it now. It does not enable us to change it.

So we plead with you, please do not dilute the thrust toward implementing appropriateness review; and please keep the pressure on State governments to get this element of the program established—soon. Until it is implemented, we are only doing half the job.

In section 206, relative to planning grants, we ask you to accept into your record an attachment to our testimony, a new AHPA study on the cost of health planning functions for HSA's.

That study indicates that the funding levels we think are needed are more or less congruent with what you propose in your bill. We would like to support the 10-percent discretionary range for the Secretary of HEW, but we are definitely against the proposal that the entire allocation be based upon the Secretary's discretion concerning "such sums as may be necessary."

It was been our experience that, under the pressures which exist in DHEW, "such sums as may be necessary" end up being very far from enough. We think the system is much safer with a basic, congressional appropriation.

The sliding scale formula in the bill is not, we feel, the final solution to the issue of fair and appropriate allocations. We would like to have your committee and staff be sensitive to developments as we go through the experience of learning what health planning is really going to cost.

Please note, however, that we have reviewed the costs as we know them thus far, and our estimate is that we see a need in the future for funding at a level 5 to 25 percent higher than the budget in your bill.

Among the reasons for this conclusion is the fact that the costs involved in acquiring expertise in cost containment—which means hiring health economists, who are scarcer than the proverbial hen's

teeth—and especially the costs involved in data assemblage and legal fees are much higher than have been anticipated.

I will give you one example. In our HSA, in order to do population-based planning well for a dense urban area, we need to have patient origin data, and that data has to be available by census tracts. But it is not available, and no one has a mandate to collect it.

In order for us to get this data from the 38 hospitals in our area, by running it off their computerized data systems, and then having it add-matched to census tracts, we would have to pay about $125,000 for just 1 year's set of patient origin information. That represents 15 percent of our total budget just to get one element for use in the base-line data set for population-based planning.

That is a lot of money, compared to what we have available.

Second, legal fees are getting absolutely astronomical. The typical certificate-of-need in the State of California involves $20,000 to $50,000 in expenditure on the part of hospitals and other institutions, most of which goes to pay lawyers.

The best we can do in paying a lawyer for our HSA is about $6,000 annually, which works out to about $500 per review to cover all legal aspects of the review: attendance, consultation, and possible defense. For all costs of $6,000 a year against $20,000 to $50,000 per review per hospital is not a fair match.

We have proposed that legislation be introduced in the State of California limit the amount of money that hospitals can spend on legal fees in connection with these reviews. It got nowhere. Until there is some kind of equity in legal muscle, we cannot deal squarely with the issues.

Legal fees paid by hospitals to their lawyers are reimbursed by medicare, medicaid, and third-party reimbursers, so it does not cost the hospital much, if anything, to throw all of this money at lawyers. HSA's cannot compete.

That is why the authorizations, we think, should be at least $40 million, $43 million, and $46 million, respectively, instead of $35 million, $37 million, and $39 million.

In section 218 on certificate-of-need, we feel that your bill makes excellent improvements, and the major improvement which impresses us is the inclusion of major medical equipment, even if not located in hospitals.

This is a major issue, especially in southern California, as Congressman Waxman would certainly know. We are witnessing some ingenious and long-range subversions of the intent of the planning law. The way it is done is this:

A hospital builds an office building next door. It is declared a private office building, even though the hospital owns it, because they own it as a real estate investment, not as an institutional service.

Then the management arranges for installation in their office building special services like radiation therapy and CAT scanners and other tertiary-level services. However, these are claimed to be operating as private practices.

However, what are private practices today, will suddenly become economical opportunities for the sharing of resources by the hospital tomorrow.

For example, in our area a large hospital has just built an office building and installed a linear accelerator which totally duplicates the oncology program at another just a few bloocks away. Then, after they got this project through the exemption process in the State of California, thus avoiding certificate-of-need review, they published in the newspapers their plan to create a regional cancer center for the hospital, and are now on a $15 million fund-raising campaign.

Now, you cannot have a decent regional cancer center without having access to radiation therapy. Down the road, this hospital is going to come in and announce that, lo and behold, they do not have to install radiation therapy as part of their hospital services. They just happen to have this wonderful arrangement with the private practitioner next door.

And, poof, they have a new, duplicative hospital service using the leverage of that unreviewable private practice situation.

We have to beat this kind of game, because it is happening all over. Your section 218 will make it possible.

We are concerned that section 218(b) (3) now excludes the purchase of a facility as a reviewable capital expenditure. That is a major loophole. We need to include purchase costs in the review process if we are serious about cost containment.

In our area, for example, the resale game is a major device for exploiting the profiteering opportunities which exist in the health care industry, because people can acquire a hospital from previous owners at an incredibly inflated rate and not be accountable for the impact that those purchase payments have on the cost of care.

An example: An institution which cost $4 million to build 4 years ago in our area was recently appraised, given inflation and additions, at $9 million. It is now on the block for purchasers who want to buyit.

The asking price is $22 million, whereas the current appraised value is $9 million. Ultimately the people who are going to pay the extra $13 million are the third-party and government reimbursement systems, or—in the case of an HMO purchaser—the membership subscribers.

In this case, the purchaser happens to be an HMO, but there are other cases of nonprofit corporations trying to buy out proprietary hospitals, or chains buying them, and the same kind of thing happens.

Such gouging of excessive profits could be prevented by a tough law with appropriate cost containment feasibility analysis required in it. We therefore think that section 218(b) (3) needs to include facility purchases.

In section 221, you have included some language about coordination with rate review mechanisms. We think that such language needs to be improved upon because it needs to address both sides of what is in fact a dual relationship.

The issue is not only that planning should take into account the issues in rate regulation or rate review, but that the rate review system should take into account planning priorities, planning decisions and appropriateness review decisions, and should not authorize higher reimbursements for services if the hospital in question maintains services which violate the health plan or which are found to be locally inappropriate.

That way we would get some meaningful leverage in the system as a whole, and planning would become something significant—not just a lot of hot air, which it too often has been in the past.

Finally, in section 224, the Area Health Development Fund, we would like to comment that, without such a fund, HSA's will again not have sufficient leverage at the local level. You talk in your bill about putting cost containment and prevention and health education responsibilities into the health plan, and into the mandated responsibilities of the HSA's.

Well, the real momentum of the local health care system has been and is now obviously in the direction of institutional aggrandizement, tertiary care, and diagnostic and treatment functions, not education, not prevention, not cost containment.

If we develop an HSP that has priorities in these new areas, as you are suggesting, the only way we are going to be able to create leverage—other than just verbal leverage—for dealing with it, is to have the kind of positive incentive that that Area Health Development Fund offers. Therefore we urge you to please maintain it, and to give the HSA's some real authority relative to it.

Finally, we are concerned about much of the sloganeering which occurs relative to the concept of accountability. In the way the health planning system has been designed in Public Law 93–641 and in the way that your amendments address it, accountability is very well taken care of.

The allegation that one must be an elected official to be accountable is simply not true. If somebody wants to be accountable, he or she has to have adequate due process procedures and has to follow them, and follow them in public.

There comes a point, however, where due process can become counterproductive and can be used as a tactical delaying device for preventing HSA's from getting down to substantial production. I see that happening. There are false due-process issues being raised.

One of these false issues is the claim that you cannot do anything accountably unless everybody is an elected official or is at least under their control. We have attendance records here of the elected officials on the boards and governing bodies in the State of California, and it is not very good.

I would like to have submitted, as background for the record, this document "Accountability, its Meanings and its Relevance to the Health Care Field," because I believe that many of the arguments you have heard and are likely to hear again in the next few weeks relative to accountability are addressed and resolved in this document, and we would like to have it available to your staff.

Mr. Rogers. Without objection, it will be made a part of the Committee's files.

[The document referred to may be found in the subcommittee's files.]

[Ttestimony resumes p. 252.]

[Ms. Hanson's and Mr. Matek's prepared statement and attachment follow:]



AMERICAN HEALTH PLANNING ASSOCIATION

TESTIMONY OF

JACQUELINE B. HANSON

AND

STANLEY J. MATEK

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE

JANUARY 31, 1978

26-219 O - 78 - pt. 1 - 15

Mr. Chairman, members of the Committee, my name is Jacqueline B. Hanson. I am the treasurer of the American Health Planning Association and the immediate past chairperson of the governing body of the Mid-America Health System Agency in Kansas City. I am accompanied today by Stanley J. Matek, the Executive Director of the Orange County Health Planning Council. We are testifying today for the American Health Planning Association, the national organization which represents health planning agencies and the volunteer consumer and provider members of their boards, as well as hundreds of planning professionals and organizations involved in the health planning process. Because of the diversity of AHPA's membership, our particular concern is to promote a health planning framework which will provide and maintain a working partnership between the 50,000 consumer and provider participants in Health Systems Agencies (HSA) and Statewide Health Coordinating Councils (SHCC) and the planning professionals who work on HSAs and State Health Planning and Development Agencies (SHPDA). This partnership must include responsibilities and roles for planning agencies at the local, state and federal levels. The planning agencies themselves must be fully responsive to their constituency in the communities, locales, and states which they represent.

I. GENERAL COMMENTS

Mr. Chairman, we have studied H.R. 10460 closely. We are convinced that the proposal contains new initiatives to integrate the concerns of local health planning agencies with statewide agencies and coordinating councils for regulation and overall plan setting. H.R. 10460 also properly expands and defines more clearly the roles of planning

agencies at all levels in achieving national goals and priorities concerned with cost containment, improved allocation of resources, increased accessibility of health care, and issues of basic equity and representation in implementing planning processes and decisions.

Mr. Chairman, you and your staff are to be congratulated for addressing the major concerns of board members and health planners and for producing a legislative proposal which, if adopted, would improve the health planning process without significantly disrupting it. You recognize that it is premature to judge the success of the failure of the planning process set forth in P.L. 93-641. H.R. 10460 is sensitive to the fact that tinkering with the organizational rules and structures of P.L. 93-641 will be destructive to the planning process unless it can improve the participation of volunteers and planners at all levels of the process. To accomodate any specific interest to the exclusion of others would have the effect of retarding the hard decisions these participants must make, and in many cases will produce a situation where individual HSAs and SHPDAs will have to start de novo, rather than from their present mobilized position.

Health planning faces a time of testing. Many of the planning entities constituted under P.L. 93-641 are just now ready to complete the substantive tasks of Health Systems Plan development and the performance of their implementation plans for project review, resource development, and cost containment. There are still major disparities in health status and access to care in this country. Thus, if we are to prepare for national health insurance this year, and if we are to avoid the escalating costs of programs like Medicare and the ever

increasing cutbacks in Medicaid benefits and programs, planning agencies must be given a chance to succeed. For these entities contain, on the whole, the most dedicated consumer and provider volunteers--people who are committed to producing better health care for their areas. Major reorganization of these agencies at a time when they are beginning to implement their responsibilities for carrying out the provisions of P.L. 93-641 will slow down resource development and cost containment activities and might produce a less publicly accountable and broadly representative governing body.

AHPA supports those initiatives within H.R. 10460 which involve state and local government officials more fully in the actual planning process. We believe it is important to take affirmative steps both through regulation and local initiative to inform, educate and involve a broad cross-section of consumers and providers, including those who are publicly elected officials, involved in health planning.

H.R. 10460 increased responsibilities of board members, HSAs, SHPDAs, and SHCCs around the country. It offers significant proposals to clarify and make more specific the agenda for planners and the coordination of priorities at each step in the planning process. It properly places strong emphasis on review responsibilities in the area of cost-containment and efficiency of service delivery without eliminating the equal need for planning bodies to be actively involved in resource development.

Equally important, Mr. Chairman, H.R. 10460 acknowledges that to perform these responsibilities, HSAs and SHPDAs must be adequately funded, and that special circumstances and conditions exist which warrant adjusting the per capita funding formula in P.L. 93-641.

H.R. 10460 is a significant proposal for the consumers and providers, who are the keys to successful health planning, and for the local, state and federal planning community. It sets forth difficult tasks at each planning level, but also provides a flexible framework.

Mr. Chairman, you know as we do that the principal block to effective health planning has been the lack of clarity regarding the role and functions of the planning agencies themselves. An HSA cannot establish its credibility in the community unless the people in that community know what an HSA really represents and whether or not that HSA is likely to endure. AHPA believes that the Congress created these agencies to deal with the controversial issues of resource development, cost control, and improved efficiency of health services. To do this effectively, we need the support of Congress, and we need its critical scrutiny.

If H.R. 10460, as passed, makes it clear that neither the federal government nor the state can override local area determinations without due process; and if it delineates the incentives and sanctions that HSAs and SHPDAs will have access to in implementing the intent of P.L. 93-641, it will send a clear message to all those interested in improving health care. This message will say: The principal, relevant factors for the evaluation of the success and continuance of planning agencies will be the degree to which they are efficient and effective in carrying out the functions under P.L. 93-641 in a way responsive to the areas they serve.

II. SPECIFIC SECTION BY SECTION ANALYSIS AND SUGGESTIONS FOR IMPROVEMENT

Section 201. AHPA fully supports the concept which would require the Secretary to monitor our progress in achieving national standards and goals, and where appropriate to revise the guidelines that have been initially promulgated. In this regard, AHPA would like to share the initial reaction of health planning agencies around the country to the January 20, 1978 final Notice of Proposed Rule Making draft of the "cost containment" guidelines. In a meeting held in St. Louis, on January 24 and 25, 1978, representatives of planning agencies from all regions of the country met to consider this set of guidelines and to suggest appropriate content and format for the forthcoming access and quality guidelines. As you may remember, AHPA fully supported the concept of using quantitatively based national guidelines as benchmarks in the planning process, but suggested that adjustments in specific standards be permitted in such areas as obstetrics, pediatrics, neonatal and intensive care to permit more effective regional planning. In addition, AHPA called for the Secretary to establish a process which would permit HSAs to demonstrate, as a function of the special conditions of their areas, whether or not a particular guideline applies and to suggest, when necessary, more appropriate quantitative levels.

AHPA and its membership are most appreciative of your role in bringing some of these problems to light, Mr. Chairman, and we are happy to report the positive reaction of our membership to this new set of guidelines. Secretary Califano and your committee are to be commended for excellent work and responsiveness to public comment. We believe too, that even with publication of these revised guidelines, considerable confusion

about the role of HSAs in implementing them will remain. For example, many rural and medically underserved areas believe that HSAs were going to take away the facilities and services that the community or region struggled so long and so hard to obtain. Congress reflected this uncertainty and concern in their passage of the resolution sponsored by Congressman Bedell to provide for greater flexibility in the guidelines for rural areas. The present guidelines do clarify the role of HSAs in implementing quantitative standards and carefully discuss the circumstances under which adjustments in the guidelines are permitted. However, we believe that the next set of national standards, those dealing with health status, access and quality, must offer the same or greater clarity in order that health planning bodies may be seen as developers as well as regulators.

Our specific concern with section 201(a) is its potential to impose heavy data collection responsibilities on HSAs. At present, local planning agencies do not have (and are prevented by statute from having) extensive data collection capabilities. We support the intent of this subsection. The Secretary should have control over the form and type of data to be collected. This has a desireable result of facilitating uniform data collection and comparison. However, full implementation of 201(a) may be impractical and costly at present. We would suggest that such data collection be limited to highly specific purposes concerning the national priorities and goals. This section should also be clarified to include language which permits the Secretary to conduct studies using representative and statistically significant samples of HSAs, so that progress in achieving national goals and implementing guide-

lines can be done in a cost effective manner.

AHPA fully supports the inclusion of national priorities dealing with cost containment set forth in section 202. Several of our proposed amendments, which we submit with our testimony, address these priorities directly. Discontinuance or conversion of duplicative and unneeded services and facilities is addressed in our amendments to section 1523(a)(4). It would permit, under the State Certificate of Need (CON) program, the recertification (usually every five years) of all institutional health services. An accompanying new section (section 1650) would also permit payments and incentives for conversion or discontinuance of unneeded institutional health facilities and services. In addition, we have mentioned, in our amendments which address priorities in the State Health Plan and the Health Systems Plan, the need to address cost effectiveness of services and promote greater efficiency and more appropriate use of health services.

AHPA is concerned by the language in section 203, which allows for redesignation of health service areas. The language beginning, "Or a change in the boundary of such areas would result in the health service area which better meets the requirements of such subsection," is particularly hard to implement in practice. How would one compare the actual HSA area boundaries in this regard against the potential of a new proposed boundary? If the intent of this language is to be fully realized, AHPA believes it would be better to add to the requirements of section 1511 an effectiveness standard. AHPA suggests that language be included which would state that redesignation be permitted only when a health service area does not meet the designation requirements of section

1511, or otherwise not permit effective and efficient health planning and development of health services. Unless such redesignation can be clearly identified in terms of this effectiveness standard, more confusion and delay in the minds of the public and the members of the boards who participate in such agencies will result, with the consequent lessening of the effectiveness not only of that HSA, but also of the practice of health planning in the area.

AHPA supports the intent of section 205 which allows the Secretary to put limits on the functions of a fully designated agency. However, this "optional" arrangement may cause misunderstanding. Members of HSA governing bodies or the public may consider a particular agreement too limiting and object to the imposition of "top-down" priorities. We suggest that this limitation in HSA functions might be handled less ambiguously by returning the HSA to conditionally designated status.

Section 206. Planning Grants. AHPA has recently completed a study on the cost of planning under P.L. 93-641. This study gathers data on the current budgetary experience and projected resource needs of fourteen HSAs. Ten HSA budgets are summarized in the paper which, with your permission, we would like to submit for the record with our testimony. The findings implicit in that study and the explicit proposals for funding of planning grants in H.R. 10460 are in basic congruence. The study found that additional responsibilities of full operation under the requirements of P.L. 93-641 and full designation would require about $.74 per capita federal contribution (including matching). This translates into a support level for HSAs of about $160,000,000. In addition, the study suggests that the passage of cost containment

legislation or increased emphases on such areas as data collection, cost containment, community education and technical assistance, and heavy emphasis on quantitative national standards in P.L. 93-641, might increase funding requirements from five to twenty-three percent. The actual increment required will of course be dependent upon the specifics of the legislation as finally enacted, and any other cost containment legislation which may be passed in this Congress which would need attention in 1979.

Both the AHPA study and your proposal advocate a basic level of support for low population and low population-large area HSAs. AHPA recommends a level of basic support for a so called, "minimum funded agency," of $275,000. This support would produce additional funding over and above that of the basic capitation rate for twenty-one HSAs (using the H.R. 10460 proposed $.70 per capita) or nineteen HSAs (using AHPA's suggested level of $.74 per capita). The additional expense of this requirement at the AHPA recommendation of $275,000 is less than $2,000,000. (The total expenditure for the nineteen HSAs under this formula of $275,000 would be $4,625,000). It should be noted that this minimum level of $275,000 would permit an HSA to employ between seven and eight fully supported professional staff members. This is, in effect, one staff member per function as specified in performance requirements set by the Bureau of Health Planning and Resource Development. The study also finds that it is not uncommon for variations of from three percent to ten percent of the total budget in travel costs which are necessary for HSAs of certain sizes and configurations. H.R. 10460 stipulates that the Secretary may have discretion to use up to ten percent

of the total grant to any HSA to assist the agency in meeting extraordinary expenses. AHPA supports this recommendation.

Section 206(b)(2) mentions specifically the extraordinary travel expenses encountered in rural areas and also unusual expenses resulting from a health system area being located in more than one state. In addition to these two special conditions, HSAs which serve several standard metropolitan areas also require special funding treatment. In cases where SMSAs are split, there are significant costs in working with other planning agencies, metropolitan planning councils, and, of course, the several governments and their local elected officials. For example, the Northern Virginia HSA must maintain a liason with the Virginia, Maryland, and D.C. governments, in addition to the separate planning agencies in each area. H.R. 10460 contains specific provisions in section 222 regarding the additional necessary requirements for HSA function when it serves split SMSAs. Therefore, it seems appropriate to include this type of HSA in the category requiring additional or extraordinary support. (It should be noted that the AHPA study found that a typical increment for these extraordinary expenses rarely exceeded ten percent and were often as low as three percent.)

In assessing the projected needs of the ten widely dispersed HSAs of diverse character, we did not find support for a sliding scale formula such as is proposed in H.R. 10460. For example, HSAs under 1,000,000 requested, on the average, $.82 per capita, including federal and local match; HSAs of 1,000,000 to 2,000,000 requested $.90 per capita including federal and local match. There may be some in-

equities produced, especially in mid-size to large HSAs as the capitation level is stepped down, particularly if the steps are too steep. However, the economy of scale argument implicit in H.R. 10460 has face validity, and neither argument can be fully supported or rejected from the AHPA study.

AHPA strongly supports section 207 dealing with the carryover of grant funds. This provision will permit HSAs to plan their budgets carefully on a prospective basis. Given the current experience of HSAs, it seems unlikely that the appropriate governing body of these agencies would permit money to be spent unnecessarily and inappropriately when they are given the opportunity to complete their job without rushing to meet end of the year deadlines.

In conclusion, regarding funding levels, we support the language dealing with the carryover of grant funds stated in section 207. We recommend that the minimum level be set at $275,000 rather than $300,000. We question whether the sliding scale capitation is appropriate given the fact that governing bodies of HSAs are unlikely to allow unnecessary expenditure of funds when the controls of section 207 and other already existing checks on spending are in place. We believe it would be better to monitor actual experience of small, medium and large fully designated and operational HSAs over a baseline period of about two years to determine what the true costs of planning are as a function of both the size of the HSA and the responsibilities they perform. We suggest that the Secretary undertake such a study.

AHPA strongly supports section 209(a)(1) but has strong reservations about the language of section 209(a)(2). We do so on two grounds.

First, if there is going to be an exception to the residency requirement, it should be across the board for consumers and providers, not just for providers. Second, it seems to us that the potential for this section to produce an unbalanced locus of control in the HSA is significant. One can draw here the analogy of how housing patterns in metropolitan areas permit "racial segregation." For example, the residences of hospital administrators, like the residence of many white collar workers who work in the central city, are most likely in the suburbs. Their participation on the board of an HSA, like that in the District of Columbia, would produce conflict and imbalanced control of health resources. AHPA believes that this amendment is unnecessary and may be counterproductive.

Section 209(d)(2), frankly, puzzles us. We are not convinced that a spouse is the sole caretaker of the special interests of his/her counterparts. Thus, the distinction between spouse and relatives as it applies to board representation does not appear to be a valid one to us. (Some would no doubt prefer their rich uncle or their son!)

The remaining subsections of 209 are, on the whole, quite appropriate. Section 209(d)(1) is particularly helpful in allowing strong supporters of planning to be members of governing bodies without the twelve month delay previously required in P.L. 93-641.

Section 210 should help to ensure broad participation in the health planning process by members of the community. Particularly supportive is the provision which requires that each agency shall make its process public and available to the Secretary for inspection. We do feel, however, that requirements of section 210 should be phased in as part

of the normal board rotation processes. This would permit existing governing bodies of planning agencies to carry out their work without major disruptions while achieving full public accountability at the local level.

Section 211(b)(2) contains a provision which we feel is inconsistent with the requirements of section 210 and other provisions of P.L. 93-641 which stress that a governing body be broadly representative of the community it serves. The requirement of having not less than ten members is incompatible with a process which would allow a group of that size to meet the broadly representative requirements. We suggest that that wording be deleted.

Sections 212 and 213 seem wholly appropriate and nonobjectionable.

Section 214, which deals with conflict of interest, contains excellent and helpful provisions. We suggest, however, that the language of 214(f) contain a reference to individuals or entities who are "direct competitors" on the matter in question. This direct competitor language disclosure request may help such institutions and organizations as health maintenance organizations, community long term care programs and other "new boys on the block," as well as prevent unfair restraint of trade or competition generally through the planning process.

We commend the Chairman for stipulating in section 215 that staff expertise is needed in financial and economic analysis and also in prevention of disease in other public health members. We would only stress that such expertise on staff is obviously related to the resources available to an HSA. This is particularly true for the minimum funded agency.

Section 216 is excellent. We strongly support this SHCC role in the development of a uniform format. We also believe that the SHCC should be involved in the setting of statewide priorities for health planning, along with the SHPDA. If there is any purpose for a coordinating council, this is it. Such councils are appointed from throughout the state and are appropriate bodies to provide input for determining statewide priorities under section 216(c). We would suggest under section 216(c)(1)(B)(2) and (3) that conforming language be developed which stipulates: "are responsive to state health needs as determined by the SHPDA in concurrence with the SHCC."

Section 217, dealing with criteria and procedures for reviews, is a wholly appropriate and important clarification of priorities and roles, for the review of state plans, under section 1532.

The amendments relating to the Certificate of Need program in section 218 are, on the whole, very strong in the areas where HSAs and SHPDAs need the most support. AHPA suggests, however, that on page twenty-six, section 218(a)(5), that both HSAs and SHPDAs have the right of appeal in this section, in addition to the applicant.

Further, section 218(b)(3), page twenty-eight, line eleven, at present excludes from the definition of capital expenditures any purchase of a facility. Purchases are by definition extremely large capital expenditures. Purchase, per se, is not directly connected with need. Its transfer of ownership provisions, however, in the past, has led to fraud and abuse. For example, hearings on nursing home fraud in New York State, held before the Senate Select Committee on Aging, have clearly shown that the greatest actual abuse of federal funds took

place as a result of the transfer of ownership from one proprieter to another (and involved transfer to members of the same family). Each time a property is sold and depreciation can be gained, opportunity for fraud and abuse exists. A general remedy to this problem would be to require all public payment programs to reimburse only for historical costs and one time legitimate maintenance costs. In addition, this section should be modified to include language which defines the nature of the one time cost and legitimate maintenance. P.L. 93-641 may be fully coordinated with other existing legislation which form the basis for public reimbursement. AHPA would be happy to work on language which would prohibit the exclusion of transfer of ownership under Certificate of Need.

Under section 218(b)(5), there is a problem in defining the locus of appeal as being the same agency that turned you down the first time. Moreover, there are appeals mechanisms which are consistent with antiquated state laws; for example, laws which require that the appeal go through the board of health or other such entity, may not improve the due process so necessary to the successful implementation of these provisions.

Section 219 represents a step in the right direction, but contains a potential anomaly as there is some ambiguity concerning the Secretary's disapproval of some things that might be approved by the state. We would suggest that the recommendations from the HSA regarding appropriateness go to the state and to the Secretary for their review. Again, we will submit language that would provide some clarification in this section on request of the Subcommittee.

Section 220, dealing with review and approval of proposed use of federal funds, requires some additional safeguards to ensure adequate area representation. In particular, section 220(b) deletes requirements of direct involvement of HSAs if federal funds are going to be used in more than one health service area in the state. This requirement (even with the opportunity for HSA comment within a sixty day period) would leave the state with by far the large bulk of review powers over federal funds. There are some problems with this, both in terms of the state's ability to review local or regional need and use of federal funds in each health service area, and also because of the potential conflict that some states may feel in rejecting federal funds, when particular substate regions may not need them and other regions may. It may well be that federal project and formula grants are needed in many areas throughout a state. However, more careful differentiation of need decisions could be facilitated by having the state make this decision in concurrence with the SHCC, and with the input of the HSAs.

In section 220, there seems to be an assumption made that for the purposes of the act, the governor and the SHPDA function as different agencies and that the governor may not know the recommendations of the SHPDA. However, for most of the decisions and review under section 220, it is the SHPDA's input to the governor that forms the basis for his decision. Governors frequently do not have time to familiarize themselves with federal grants and make the decision on a grant by grant basis. Such functions are typically delegated to the Commissioner of Health or appropriate party.

Section 221. Coordination of health planning with rate review. The language of this section is too vague to have much effect. In the first place, it stipulates that the HSA coordinate itself with the state rate review agency. Coordination implies a dual responsibility. One party cannot coordinate something if the other party does not join in that coordination. The Secretary could have some role in tying these parties together, but the decisions still must appropriately go to the state level. There should be a direct linkage of section 221 to the references below in section 225(c) (Section 1526(e)) which calls for authorization for rate review. Any entity receiving dollars under these sections should be required to coordinate its programs with the HSA. In addition, language should be added which would deny the authorization of these funds (under certain conditions) when review agencies did not take into account the recommendations of HSAs. For example, if an HSA finds a service to be inappropriate (after normal due process and review at the state level) rate setting and budget defining procedures should not be performed by the rate review agency. Correspondingly, HSAs and SHPDAs should be required to include as part of their planning and review processes data generated by the rate setting agency for particular facilities and services. HSAs should also be required to conduct additional economic analyses where appropriate in planning for project review. The priorities in H.R. 10460 and additional staffing requirements for such economic expertise would permit such activity. We believe that such requirements would be more conducive to a true coordination of function between the rate review

agencies and the state planning agencies.

Section 223, which deals with SHCC composition, is difficult to implement without causing severe disruption in the existing planning process. If one accepts the roles of the SHCC in coordinating planning, one should test out the functions of these agencies with their present composition intact. Against the possible need for proportional representation, one must weigh the size and functional decision-making capacity of a large SHCC. The purpose of a SHCC is to reflect a statewide consensus, not to allow the concerns of one particular area to outweigh the concerns of another. The present SHCC composition would not necessarily lead to underrepresentation of urban areas in the development of the State Health Plan. The governor may, and historically does, appoint the remaining forty percent of the SHCC to balance out such requirements for proportional representation. In addition, the formula suggested in section 223 is ambiguous with respect to the size of an HSA which should be considered for minimum representation (two members) on the SHCC. This formula may thus be inequitable in differentiating between the HSAs of different population who have the minimum number of representatives on the SHCC.

Section 223 also gives the governor the opportunity to appoint the chairman of the coordinating council. AHPA does not believe this would have a strong negative or positive effect in terms of facilitating or retarding the planning process and planning decisions. However, the procedure may prove offensive to the communities in the health service area which the majority of SHCC members represent. Historically, such councils and commissions have had the prerogative of appointing from their own group a member to serve as their chairman.

By eliminating this option, the delicate balance of local and state interests may be disrupted.

Section 224. Authorizations. AHPA recommends that authorization levels for HSAs for the first fiscal year should be $160,000,000 with succeeding authorizations being based on the cost of living escalator, up from 6.6% to 7.0% per year. The authorization levels in succeeding years would be $72,000,000 and $185,000,000. In addition, the strongly increased responsibilities and functions of the SHPDA in its staffing of the coordinating council, its increased roles in Certificate of Need and appropriateness review, and in its role of speaking for the governor in connection with federal grant review seem to require substantial increments in authorization for the years specified. We would suggest that the authorization levels for the three years of the implementation of the act be $40,000,000, $43,000,000 and $46,000,000.

We are particularly gratified to see the strong commitment which H.R. 10460 makes to the health resources development fund. We are fully supportive of the authorization levels you have suggested. We further wish to suggest that these authorization levels urgently need translation into a formal appropriations level which will be supportive of resource development, which for many HSAs is a very high priority item.

AHPA has offered its own amendments relating to section 1625 which are compatible with the proposals outlined in H.R. 10460. We strongly support this section and believe special attention must be given to the problem of eliminating safety hazards in public facilities.

Mr. Chairman, this concludes our testimony. We thank you for giving us this opportunity to present our views.

Appendix A
AHPA Testimony before the
House Subcommittee on Health
and the Environment
Jan. 31, 1978

THE COST OF PLANNING UNDER PL 93-641 (95-83)

Current Experience and Projected Needs of Ten HSAs

A Resource Paper
Prepared by

THE AMERICAN HEALTH PLANNING ASSOCIATION

in Cooperation with its Member HSAs

January 27, 1978

INTRODUCTION

Adequate funding of the health planning agencies established under PL 93-641 (the National Health Planning and Resources Development Act of 1975) is a basic issue to be addressed by the Administration and Congress, as it considers renewal of the planning law. With few exceptions, the Health Systems Agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) created since 1975 have not achieved full function or full designation. Some of these agencies have previously functioned with a different charter under State health laws or the new now superceded comprehensive health planning act. In addition, historically, regions of the country and within the states differ widely in the level of health planning activity they are able to meaningfully and cost-effectively absorb. Finally, additional functions, emphases, and priorities may be added, either via additions to the planning law, or through new legislation such as the hospital cost-containment proposals.

Consequently, the present levels of funding of such agencies are not necessarily a good index of the level of support they require to function productively within their charter. This paper approaches the question of Federal funding from the perspective of assigning financial resource needs of the planning agencies as a function of the increased responsibilities that result from or are associated with the implementation of a Health System Plan and "full designation" and National Federal requirements.

1.0 Purpose of the Document: To determine an appropriate National level of support for HSAs for Fiscal Year 1979, within the context of the work program and priorities specified under PL 93-641 and other planning directives and keyed to standards and areas of performance set by DHEW.

2.0 Guiding Assumptions of the Funding Approach: Defining an appropriate level of Federal financial support of HSAs is contingent upon an assessment of:

1. Whether or not HSAs will have increased responsibilities as they achieve full operation/full designation in the next year;

2. The need to undertake efforts to deal with problems inherent in the health planning process that have arisen as a result of health planning efforts already performed by HSAs.

Allocation of planning funds cannot be based on the cost-effectiveness of health planning activities, since meaningful measures have not yet been developed. However, the consequences of not funding at a particular level can be indicated in terms of functions that may or may not be performed under a given level of support. The approach taken in this document was therefore based on a model that reflects a consensual approach to determining a meaningful level of per capita support for HSAs and an assessment of individual differences and special needs of HSAs of particular sizes, economic and demographic characteristics, and mode of organization.

2.1 The major factors which warrant additional funding for most HSAs are a function of the increased responsibilities they must assume as they become fully operational.

2.2 There are increased responsibilities that result from or are associated with the implementation of a Health Systems Plan and "full designation." These include:

- Plan Implementation Activities:
  This will represent a major work element for most agencies. Most agencies will require at least three to four planners regardless of size of agency to handle implementation activities. It is important to recognize that developing and maintaining HSPs and AIPs is an ongoing process. Most agencies will not be able to meet new work requirements by wholesale shifting of planners from plan development to plan implementation activities. In an "average" size agency one may be able to shift one or two professionals, but not the entire complement of staff.

- Federal Grant Review (approval and disapproval):
  This function will for most agencies require the time of at least two professional staff and support services in addition to current project review (certificate of need and section 1122) staff efforts.

- Appropriateness Review:
  Because of the current lack of specificity and prioritization of the functions which fall under this rubric, it is very difficult to estimate resources required. However, those agencies which make a major effort to eliminate unneeded services and facilities will find it a major undertaking. Assuming that the agencies have strong project review capabilities, it may need as little as one additional full-time equivalent (FTE) to staff such functions.

- Recommendation (to the SHPDA) on Priorities for Facility Modernization, Facility Conversion, Etc.:
  This should not require more than 0.5 FTE additional staff.

Thus, typically, the additional responsibilities of full operation and designation will require at a minimum an additional 4.5 professional staff (FTE) with appropriate support and possibly as much as 8.5 to 9 additional staff.

2.3 There are additional responsibilities that may be included in renewal and/or other associated legislation or regulatory mandates:

- Strong emphasis on cost containment: Health planning agencies will have to gather, analyze, and publish substantially more cost/charge and utilization data. HSAs may also be required to investigate complaints of violation of revenue ceilings. Perhaps even more important, HSAs would have to develop appropriate strategies and undertake negotiations to insure the capital allocation process is implemented properly. If "decertification," "discontinuance," or "conversion" of facilities was made part of cost containment legislation, HSAs would in addition face greater responsibilities to prove

and defend its review and comment on particular facilities in addition to public meetings, administrative hearings, and, quite possibly, as part of a judicial review process. The per capita estimates reported in Table IV under the heading of "cost containment" indicate that agencies require from 1 to 3 additional FTE staff trained in economic analysis who will carry out these functions. In addition, there may be need for technical or legal support required on an occasional (consultant) basis. If subsequent revisions of PL 93-641 require cost containment or a form of cost containment legislation such as HR 9717, S 1391, etc., becomes law, most HSAs will require 2 FTE to carry out their functions.

- Implementation (application) of National Health Planning Guidelines: This function is already in law, but additional emphasis on achieving quantitative objectives, to the extent such objectives are non-overlapping with cost-containment priorities, will require additional staff analysis and place heavy emphasis on negotiation functions with providers in order to achieve nationally established guidelines on a regional basis or to develop adjustments to the guidelines suited to particular locales. Some already well-staffed planning agencies may not require additional staff for this function; others will require from 0.5 to 1.5 additional staff.

- Increased Community Education and Technical Assistance Efforts: At present there are no legal requirements for special planning agency efforts to educate and provide special technical assistance to the public. However, DHEW is currently requiring through memoranda and policy pronouncements much greater "public relations" and "technical assistance" efforts by planning agencies, including developing a full public forum for publication, considerable discussion of DHEW proposals. DHEW also is requiring additional planning coordination efforts between HSAs and local, regional, and state governments as well as specific interest groups of providers and consumers. There have also been proposals for special or exclusive additional training of consumer board members or local elected officials perhaps even through the creation of staff support outside HSAs and SHPDAs. This of course could be handled by a separate grants mechanism to consumer groups or public agencies. However, if one accepts the idea that such functions are best carried out in the context of staff-board interaction as part of an overall planning effort, an additional 1.0 to 1.5 FTE staff would be needed for such purposes.

To carry out the tasks in these three additional areas would require from 4.5 to 6 additional FTE professional staff.

2.4 There are special factors which may lead to differential costs between HSAs. (In the methodology described below, these factors were addressed using a common vocabulary in each instance where they had significant impact on the cost of operation of an HSA. The most critical are:

- Distance/population density factors
- Population distribution and mix and minimum requirement for serving an area's population (capitation requirements notwithstanding)
- Number of subarea councils and other sub-units
- Data base availability
- Prevailing wage rates in an area
- Legal costs incurred in defending the actions and functions of the agency as part of due process.

Additional impact on the cost of planning may to some extent be a function of the number of political jurisdictions in an area, the number and variety of health care delivery and training units in an area, the presence of other (non-PL 93-641) planning bodies, applicable State or local health legislation and regulation, the special rural, ex-urban or urban needs, and the planning "tradition" in the area including the awareness, attitude, and level of participation of both consumers and providers. (The degree to which the health care system meets the requirements of the health status of the system.)

2.5 Additional resources requirements may also be needed to solve problems inherent in the health planning efforts of the last several years. Chief among these is the need for additional resources to improve data acquisition, management, and analysis activities. Existing data systems (CHSS, PSRO, Medicare Cost Reports, etc.) are not yet adequate for health planning purposes either because specific data elements necessary for planning are lacking, formats for data output have not been developed, or legal and other restrictions inhibit sharing of data. However, even if such difficulties are overcome in the near future each HSA must acquire and analyze large amounts of local (health service area) data which would not duplicate other data collection efforts. As many as 2.0 to 3.5 additional staff may be needed for this purpose.

3.0 The Cost-of-Planning Model: methodological approach and format.

3.1 Methodological Approach:

To address the issues described above, write the objective of arriving at a realistic National level of support for HSAs. Executive directors (and, where appropriate, professional budgeting or accountant support) of twelve HSAs were brought together to develop a workable model for generating staffing and cost requirements. The agencies selected were from all regions of the country. They reflected the full spectrum of population and other demographic characteristics of HSAs. Some were high-population small area HSAs; others low-population large area HSAs; still others, variations and mixtures of rural and urban characteristics. The HSAs sampled were from the following states: Arizona, California, Florida, Maine, Maryland, New York (2), North Carolina, Oklahoma, West Virginia, Wisconsin and Wyoming.

A model was developed for a hypothetical average population HSA of 1,000,000. Participants in the study developed working definitions of the functions to be performed by each agency (keyed to provisions of PL 93-641 and the performance requirement under seven areas specified by the Bureau of Health Planning/DHEW). An in-common approach to staffing and cost accounting was developed.

The method used to derive the cost of one "fully loaded" professional staff (FTE) - that is, a professional staff with necessary support staff and with all elements of overhead factored in - was that of dividing total budgeted expenditures (or where available actual expenditures) by the total number of FTE staff. A decision was made not to weight FTEs by salary level or by function because the variations among functions would be less than 5 percent.

Each HSA director then calculated his actual FY 77 and 78 expenditures under column II of the model (see below) and developed projected expenditures under the conditions of full operation (column III) and full operation plus additional functions (column V of the model).

It should be noted that all FY 77 and 78 budgets reported included the actual amount of matching funds the HSA was able to generate. In at least two cases (HSAs D + G) this was a significant portion of the budget - 20 to 35 percent. Therefore the projected capitation figures reported in the model include matching funds. In

determining authorization levels for Federal financial participation exclusive of matching approximately 8 percent of the $0.80 per capita reported may be deducted. A per capita amount of about $0.74 would, thus, reflect the required level of Federal support (including Federal matching funds and excluding the local match dollars) which permits full implementation of the functions presently prescribed in PL 93-641. The addition of functions listed in column IV of Table 1 in any renewal legislation could add as little as $0.04 FFP or as much as $0.13 FFP (on the average) to that figure. This range is of course dependent on the additional functions specified in the renewal legislation (cost containment - $0.08; quantitative guidelines in addition to cost-containment - $0.06; community education, technical assistance - $0.04).

3.2 The Cost-of-Planning Model:

See Attachments A & B for a full description.

4.0 Results:

Tables 1 and 2 below display per capita requirements for HSA funding in FY 79.

5.0 Special Consideration:

5.1 What funding formula(s) or funding system(s) is(are) most appropriate to sustain full HSA activity?

The present funding mechanism for HSAs has three concepts:

- a direct per capita allotment
- a Federal match on eligible funds used locally
- a ceiling of $3.75 million, regardless of the HSA's population.

The data displayed on Table 2 lends support to the idea that these mechanisms may need to be supllemented by a minimum level of support for low population HSAs. It is suggestive of a trend that would permit the use of a sliding formula which allocates higher per capita support to the first 1,000,000 population of an HSA and progressively lower levels of capitation funding for additional population levels in the area. For example, HSAs under 1,000,000 requested $0.82 on the average; HSAs of 1,000,000 - 2,000,000 requested $0.90. The latter proposal would be difficult to implement because discontinuities exist as the capitation level is stepped down. However, the economy of scale argument can neither be support nor rejected from the available date in this study.

5.2 The minimum funded HSA; what is a realistic level of support?

There are sixteen HSAs with area populations of less than 330,000. Most of these are also large area HSAs. For these HSAs, we suggest that, at a minimum, a level of staffing be considered which permits one full-time equivalent with necessary support staff be assigned to each performance function specified by the Bureau (the actual staffing distribution by function may of course vary by HSA).

The "fully-supported" cost of one full-time equivalent as determined in this survey ranges from $32,000 to $45,000 (this figure includes all support staff and other overhead items exclusive of specific travel funds for HSAs whose populations are widely dispersed and distant). Thus, for a fully operational low population HSA, the actual cost of operation would range $224,000 to $315,000 (median $269,000).

A minimum support figure in the range of $275,000 seems adequate as a basic resource level which permits full spectrum planning and public involvement consistent with the requirements of PL 93-641.

5.3 Travel and related costs in small population, large-area HSAs and bi-State HSAs.

One agency (listed as J on Table 1) is typical of large-land area, low-population density, widely dispersed HSAs. Agencies such as these face difficulties connected with time and travel; for example, the average travel distance for Board members is either 340 or 348 miles. In addition, there are no regularly scheduled airlines which traverse these points. Travel costs for the one year of Agency J's conditional designation amounted to more than $25,000, or 17 percent of the total agency budget.

Other moderate or small area HSAs with similar population status to Agency J typically have travel budgets ranging from 7-9 percent of travel budgets for board and staff. Still other HSAs with similar size and population density to Agency J may have 80-90 percent of their populations located within a few miles of the HSA's base of operations. In such cases, although population density may be low, the necessity for and cost of the travel is also relatively low.

Certain HSAs which serve more than one state or multiple SMSAs are required to, in effect, double, or in the latter case even triple, their liaison activity with SHPDAs, sets of public officials, and other public agencies and constituencies.

Cost of travel is therefore predictable only when more factors than the area's population of its size are taken into consideration. It is not uncommon that variations of 10 percent or more of the total budget in travel costs are possible between HSAs of similar population.

However, an additional allowance of from 3-10 percent of total budget may be needed for extra travel costs, to provide additional staff and other resources to support subarea councils in large, sparsely populated HSAs, and the special needs of bi-state HSAs and HSAs which serve two or more SMSAs.

6.0 Overall projections of support requirements:

From the accumulated data, fiscal 1979 requirements for HSAs under the conditions of full implementation of PL 93-641 amount to $160,740,000. This includes a basic per capita of $0.74 on 191 HSAs with a combined population of 201,000,000, amounting to $148,740,000. An additional $4,625,000 is required by nineteen agencies with populations less than 344,000 funded at the recommended level of $275,000 and an additional $7,500,000 from two maximum funded agencies ($3,750,000).

To the basic FY 79 support of $160,740,000 an estimated cost of living escalator of from 6.6 percent to 7.0 percent per year must be added for the years 1980 and 1981. Thus funding support levels for those years would be roughly $172,000,000 for FY 80 and $185,000,000 for FY 81.

Increments of from 5 percent to 23 percent would be required to be added to the basic level of $160,740,000 to support the additional responsibilities of cost containment, implementation of quantitative national standards and goals, and community involvement and technical support for consumers, local elected officials and selected providers. This increment of course would be dependent on the passage of additional legislation or significant amendments to PL 93-641.

Attachment A

HSA FUNCTION

1.0 Agency Organization and Management

1.1 Maintain agency organization and management, including policy development and administration, financial administration, personnel administration, and work program development and evaluation.

2.0 Plan Development*

2.1 Develop, annually review, and amend as necessary a health systems plan (HSP), a statement of goals for the area (Sec. 1513(b)(2)).

2.2 Establish, annually review, and amend as necessary an annual implementation plan (AIP) describing objectives and methodologies for achieving the HSP goals (Sec. 1513(b)(3)).

3.0 Plan Implementation/Review Activities*

3.1 Review and approve or disapprove each proposed use in area of federal funds appropriated under federal health legislation, or made available to the state under a federal formula grant (Sec. 1513(e)) (Such as Community Mental Health Centers, Alcohol Abuse and Rehabilitation)

3.2 Review and make recommendations to state health and development agencies regarding new institutional health services in area institutions (Certificate of Need) (Sec. 1513(f)).

3.3 Review and make recommendations to the SHPDA regarding the appropriateness of institutional health services. (Sec. 1513(g)).

3.4 Recommend to the SHPDA projects for modernation, construction and conversion of medical facilities to achieve the HSPs and recommend priorities among such projects (Sec. 1513(h)).

4.0 Plan Implementation/Health Systems Development*

4.1 Develop and publish specific plans and projects for achieving the objectives established in the AIP (Sec. 1513(b)(4)).

4.2 Provide technical assistance to individuals and entities in the area for development of projects and programs in accordance with AIP priorities (cost control, integration of services) (Sec. 1513(c)(2)).

4.3 Provide financial grants-in-aid or contracts for projects consistent with AIP priorities (Sec. 1513(c)(2)).

5.0 Data Management and Analysis

5.1 Assemble and analyze data on the status of health in the area and on health resources in the area (Sec. 1513(b)(1)):
(A) the status (and its determinants) of the health of the residents of its health service area.
(B) the status of the health care delivery system in the area and the use of that system by the residents of the area.

*NOTE: These activities may be functionally interchangeable under some circumstances: staffing requirements for these functions will, accordingly, reflect an individual HSA's progress in performing cyclically related sets of activities.

HSA FUNCTION

(C) the effect the area's health care delivery system has on the health of the residents of the area,
(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,
(E) the patterns of utilization of the area's health resources, and
(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

6.0 Coordination

6.1 Coordinate activities with PSRO's, those entities part of the demonstration cities act, regional planning commissions, and other local and regional planning bodies (Sec. 1513(d)) and where appropriate develop written agreement and/or technical assistance relationships with these entities.

7.0 Public Involvement and Education

7.1 Public information and education, election and orientation, and orientation and election of board members, procedures for involvement of public officials and others.

Attachment B

Your HSA Area Address _____

_____

_____

Your HSA Area Population _____
(Rounded to nearest 10,000)

FUNCTION (See attachment for definition of functions)	A. CURRENT REQUIREMENT* 1/		B. FULL OPERATION*		C. COMMUNITY/ CONSUMER EDUCATION & TECHNICAL ASSISTANCE*	D. HSA ROLE IN IMPLEMENTING NAT. GUIDELINES*	E. COST CONTAINMENT*
	Staff (F.T.E.)	Cost	Staff	Cost			
1.0 AGENCY ORGANIZATION AND MANAGEMENT	1-2		3**				
2.0 PLAN DEVELOPMENT	3½-4		5-6				
3.0 PLAN IMPLEMENTATION/ REVIEW ACTIVITIES	1½-2½		4-5				
4.0 PLAN IMPLEMENTATION/ HEALTH SYSTEMS DEVELOPMENT	2-3		4				
5.0 DATA MANAGEMENT & ANALYSIS	2		3				
6.0 COORDINATION	½		½-1				

1/ NOTE: Column A is not strictly comparable with Column B since, at present, HSAs vary widely in their actual implementation of functions of PL 93-641, often as a condition of State circumstances or development of HSPs and AIPs.

FUNCTION	A. CURRENT REQUIREMENT		B. FULL OPERATION		C. COMMUNITY/ CONSUMER EDUCATION & TECHNICAL ASSISTANCE	D. HSA ROLE IN IMPLEMENTING NAT. GUIDELINES	E. COST CONTAINMENT
	Staff (F.T.E.)	Cost		Staff Cost			
7.0 PUBLIC INVOLVEMENT & EDUCATION	½-1		1-2				
TOTALS	11-14½		21½-24				

*See accompanying memo for definition ** "Average size" HSA serving a population of 1,000,000

STAFF COMPLEMENT (see section 3 in accompanying memo)	A.	B.
Equation for deriving cost of one "fully loaded" professional staff (F.T.E.) (see section 4 of memo)		

Discussion of variables which affect your HSA's cost of operation (see section 5 of memo)

TABLE 1

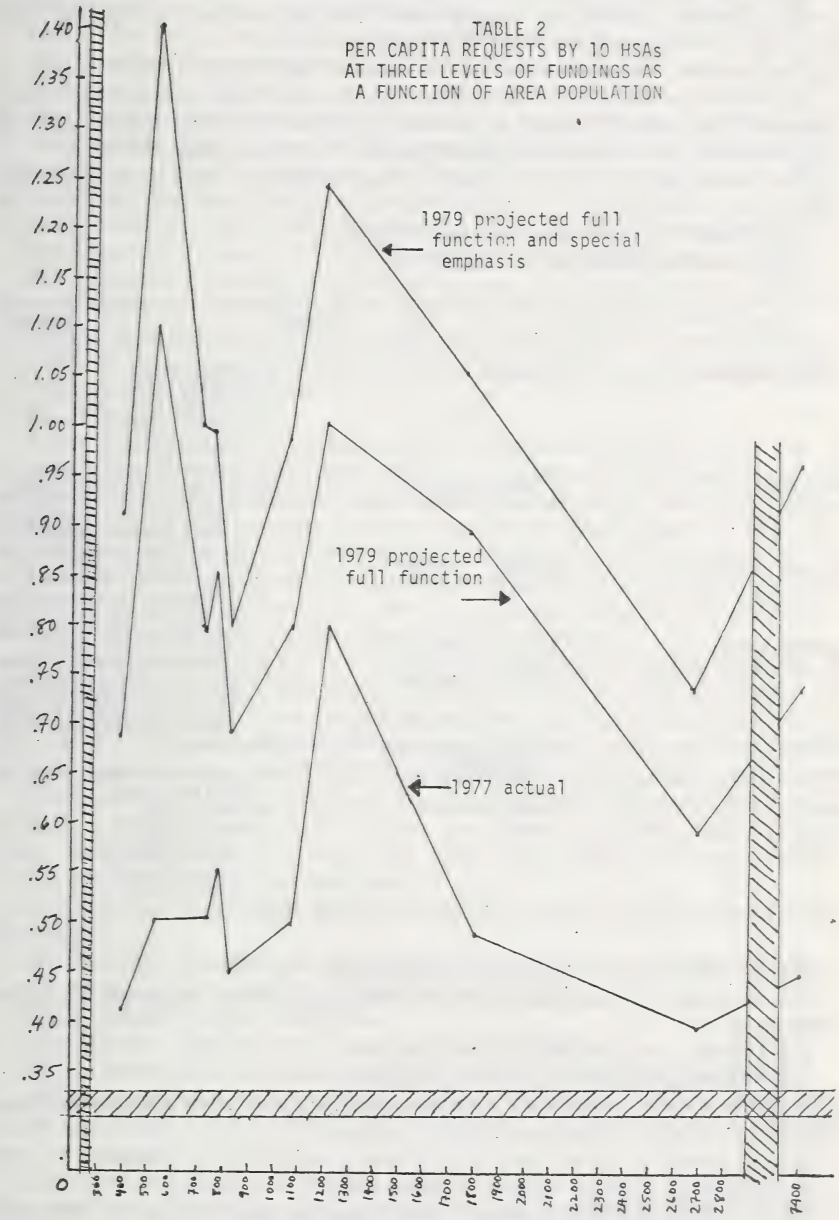
PER CAPITA SUPPORT REQUIREMENTS IN CENTS FOR 10 HSAs - CURRENT DATA AND PROJECTED FIGURES BY HSA

HSA Agency	I Area Population	II Current Requirement per capita (in cents)	III Full Operation per capita (in cents)	IV Full Operation with additional focus on three priorities			Total
				A Consumer/ Community Educ. & Tech. Ass.	B Imple- mentation of quant. Nat. Guide- lines	C Cost Contain- ment	
A. Southeast[1] Rural[2] Large[3]	560,000	.50	1.11	.03	.09	.17	1.40
B. Mid. Atlantic Metro/Suburban Medium	810,000	.45	.68	.03	.02	.07	.80
C. Northeast Urban/high density Small	7,570,000	.44	.74	.04	.06	.07	.91
D. Northeast Urban/Rural Mix Medium	1,200,000	.80	1.02	.04	.06	.11	1.23
E. Southern Urban/Rural mix Medium	740,000	.51	.78	.04	.09	.09	1.00
F. Mid-Western Mixed (Single-State) Urban/Rural Large	2,710,000	.39	.54	.05	.07	.07	.73

[1]Area of region [2]Type of region [3]Size of region

HSA Agency	Area Population	Current Requirement per capita	Full Operation per capita	Full Operation with additional focus on three priorities			Total
				Consumer/ Community Educ. & Tech. Ass.	Imple- mentation of quant. Nat. Guide- lines	Cost Contain- ment	
G. Mid-Atlantic Suburban Small	1.050.000	.50	.80	.08	.00*	.06	
H. East-Central Predom. rural/ large metro-sing. state Large	1,800,000	.47	.88	.03	.07	.06	1.04
I. North-Central Rural-1 small city Medium	800,000	.56	.85	.01	.10	.03	.99
J. Western Rural-single state Large	400,000	.44	.68	.09	.07	.07	.91
AVERAGE--	MEAN	.51	.81	.04	.06	.08	.99
	MEDIAN	.49	.79	.04	.07	.07	.93

*Already included in the full operation per capita of the HSA


TABLE 2
PER CAPITA REQUESTS BY 10 HSAs
AT THREE LEVELS OF FUNDINGS AS
A FUNCTION OF AREA POPULATION
1979 projected full function and special emphasis
1979 projected full function
1977 actual
1.40
1.35
1.30
1.25
1.20
1.15
1.10
1.05
1.00
.95
.90
.85
.80
.75
.70
.65
.60
.55
.50
.45
.40
.35
0
300
400
500
600
700
800
900
1000
1100
1200
1300
1400
1500
1600
1700
1800
1900
2000
2100
2200
2300
2400
2500
2600
2700
2800
7900

Mr. MATEK. Thank you very much for your time.

Mr. ROGERS. Could you also submit for the record the figures you have on attendance by public officials?

Mr. MATEK. Yes, sir. At this time, I have only handwritten copies.

It contains such interesting items as the fact that one agency body has not been able to have a governing board meeting since May of 1977 because they could not get a quorum of county supervisors.

The data is here. If you want it handwritten, I can give it to you like this.

Mr. ROGERS. I think that would be fine.

[The material referred to follows:]

Agency	Meetings	Attendance
Northern California	10 meetings	3 county supervisors: 1 absent 7 times. 1 absent 3 times. 1 absent 2 times. 2 county executives: 1 absent 9 times. 1 absent 5 times.
North Bay	G: Body 12 meetings	1 county supervisor: Absent 6 times.
	G: Board 8 meetings	2 county supervisors afisent 8 times. 1 county supervisor absent 7 times. 3 county supervisors absent 3 times. 3 county supervisors absent 0 time.
Alameda- Contra Costa	G. Body: 11 meetings	2 county supervisors absent 1 time.
	G. Board: 8 meetings	2 county supervisors absent 4 times. 2 county supervisors absent 2 times. 1 county supervisor absent 3 times. 1 county supervisor absent 0 time.
North San Joachin	G. Body: 11 meetings	1 city councilman absent 7 times. 1 city councilman absent 4 times.
	G. Board: 13 meetings	2 county supervisors absent 4 times. 1 county supervisor absent 7 times. 3 county supervisors absent 2 times. 1 county supervisor absent 1 time.
Midcoast	G. Board of 8 county supervisors "hardly any meetings"	No quorums.
Golden Empire	G. Board: 9 supervisors.	No quorums for meetings since May 1977. 6 efforts made.
Inland	G. Body: 12 meetings:	6 elected officials: 1 absent 6 times. 1 absent 5 times. 1 absent 4 times. 2 absent 2 times. 1 absent 1 time.

Mr. MATEK. Do you have any questions?

Mr. ROGERS. Thank you for your statement. Your suggestions have been good.

Dr. Carter—yes, we will have questions.

Mr. CARTER. Thank you, Mr. Chairman.

I noticed you mentioned rate review, both of you. Where do you think this should take place, and by whom?

Ms. HANSON. Rate review, sir? Where should it take place?

Mr. CARTER. And by whom, at what level?

Ms. HANSON. I think it should take place at the State level. When a health systems plan is being produced, and ultimately a State health plan, there should be a place in that State for a rate review system against which we can measure our recommendations. At the same time that that law is being implemented, agencies they can be aware within their own State what the priorities are of the health planning process.

It seems to me a more compact system, and I think it provides a workable system, since we frequently have interaction, with the Governor of the State, the legislatures, and so on.

Mr. CARTER. Do you think that the rate review board should be independent of the HSA?

Ms. HANSON. Independent of? Yes, sir, I think the bulk of its membership surely should not be HSA people. I think some HSA representation would be useful, simply because the planning process that an HSA follows may not be quite as familiar to those individuals who would qualify in other areas to serve on a rate review commission.

But in no way should HSA's dominate a rate review commission.

Mr. CARTER. I certainly agree with you. I do not know if HSA's should really be involved in it. I agree with you on both counts.

I want to thank you for your excellent ideas and your contribution.

I notice you, one of you mentioned, discontinuance of unneeded facilities. Would you address that?

Mr. MATEK. Yes, sir.

Your bill, in section 202, has a brief statement which says that it is a priority to discontinue duplicative and unneeded services. Now, as to how that happens, I think there has been talk about creating a buy-out fund. It is unfortunate that we need to create a fund to buy our institutions which should not have been built in the first place.

Licenses are fundamentally privileges, and that State government ought to have the authority to revoke a license which is demonstratively being used against the overall public interest.

However, I understand the history of case law in such matters. I understand that the concepts of private property and the right to make a living, enter into the situation; so a buy-out fund may be a practical compromise. I think you could create one and test it for awhile, and then see whether it should be expanded or eliminated.

Mr. CARTER. If it is being used against the public interest, we would expect it to be closed. But suppose you have a 50-bed hospital and your occupancy rate has been less than 70 percent and some people think it advisable to close ten beds.

But, if you close those beds, would that result in a saving to the hospital?

Mr. MATEK. Congressman, when you close down a single ward in a small hospital, you usually cannot save anything.

Mr. CARTER. I agree with you.

Mr. MATEK. You have to close the whole facility.

Mr. CARTER. You are exactly right. I think you are right on that.

What would you do, in a case like that, if you had 10 beds that you were not using, that you could do without, as far as hospital patients are concerned?

Mr. MATEK. What our health plan in our area recommends is that they convert them to nursing home beds and, instead of charging $140 a day for the bed they charge $25——

Mr. CARTER. You could have either skilled care, then, or intermediate care.

Mr. MATEK. This is not an economically attractive alternative from the point of view of the hospital administrator, but I think it is time to start making it attractive, either through positive incentives or negative ones.

Ms. HANSON. Dr. Carter, may I comment on that for just a minute?

Mr. CARTER. Yes, ma'am.

Ms. HANSON. I think, depending on the location of the facility, if it is in a rural location, maybe Mr. Matek's solution could be the only one. But there are, in urban areas, a number of very small hospitals that have been functioning for a great many years. I think one of the roles of the health systems agency is to be a convenor or forum for those services in the community which are marginally economically sound, for the purposes of either doing away with duplicative services, or being a convenor to find ways that cooperative arrangements can be entered into so that institutions A and B may merge to become C.

Now, I know this flies in the face of all kinds of protection of one's rights and a number of other things, but I also suggest that, in the public interest, that if there is not a specific availability or accessibility problem—because you are in an urban area—it could well be that you could convert two economically marginal institutions into one that could be an economically viable one, produce a public service, to continue serving that community or that portion of the community.

I think the HSA can serve a tremendous role in being the convenor of these kinds of discussions.

Mr. CARTER. I want to compliment you on that. I think that is an excellent idea.

Thank you very much for your very excellent testimony.

Ms. HANSON. Thank you, Dr. Carter.

Mr. ROGERS. Mr. Satterfield?

Mr. SATTERFIELD. Thank you, Mr. Chairman.

I would like to pursue the question that Dr. Carter brought up and make sure that I understand. When you mention closing beds or facilities, I suppose we are talking about some sort of periodic review with the idea that if they are found not to be needed, they would be closed.

Is this what you feel should be done?

Mr. MATEK. Well, first of all, Congressman, I believe that the issue of closing beds is fundamentally a regulatory function, which means it is a State government function.

The function of the HSA is to identify what is needed and what is appropriate and what ought to happen.

Mr. SATTERFIELD. Well, I will come back to that in a second, but——

Mr. MATEK. The muscle in this case, if it exists, is properly a governmental power. Now, the idea of appropriateness review, as it has been proposed, is that there be certain time periods allowed for conversion from an inappropriate service to a more appropriate service, and that people try to work with the institution in creating the changeover.

That changeover may require economic stimulus or a development fund grant, or something like that. If, after a certain period of time, the changeover is not made, I do not believe that the ability to simply close them down now exists. But surely the ability to cut off Government reimbursement to support the institution or the inappropriate service does exist and is a feasible alternative.

Mr. SATTERFIELD. Does it bother you that, in this process, we may be making it virtually impossible to obtain private financing for any new construction, because the financiers would be very hesitant to advance money for a facility if its capability for producing income could be changed at any time through this process.

Does that bother you at all?

Mr. MATEK. As a matter of fact, our agency has been trying to deal with that issue. We have been writing letters to lenders urging them not to make loans to facilities that violate the local health plan. We have told them that we would be glad to serve as a data resource to the people who make mortgage loan decisions. If an institution is appropriate, and is following the health plan, we would like to support their getting mortgage money.

Mr. SATTERFIELD. That is not my point. Let's say you get a certificate-of-need for a new facility and you are going to get private financing. Who is going to lend the money for private financing if 2, 3, 4, 5 or 10 years down the road they might shut the facility down or convert it from a hospital to a nursing home?

How are they going to get private funds?

Mr. MATEK. If they get a properly researched and supported certificate-of-need, then as far as I am concerned they are home free, and anybody who grants a certificate of need which can be reversed——

Mr. SATTERFIELD. In other words, a certificate-of-need should be held in perpetuity.

Mr. MATEK. I think it should be held for the term of the loan, but I think such certificates should be harder to get. It should be nearly impossible to get a certificate-of-need that does not have a longrange plan attached to it which addresses community-wide supply and demand issues and the directions in the local HSP.

Mr. SATTERFIELD. Would you recommend, then, that we add language to the act which states that a certificate-of-need should be coincidental in length of time with any mortgages and loans in connection with the construction of a facility?

Mr. MATEK. I would prefer to see State guarantee loan programs tied to the conclusions of certificates of need and the HFP. That is the kind of coordination and regulation we need.

The private money market is going to do whatever they think is profitable. As one lender put it to me "our money has no morality."

Mr. SATTERFIELD. But State guarantees of loans, you know, depend on the State legislatures, and we are talking about something that may never happen and something over which we have no control.

I am talking now about Federal legislation, and that is the only thing that we can address with confidence.

Ms. HANSON. Mr. Satterfield, may I comment on your question?

Mr. SATTERFIELD. Yes, I would be happy to hear your comment.

Ms. HANSON. The issuance of certificates-of-need in the future, which is really what we are dealing with in this law and in the one before it, is the thing that we are endorsing from the AHPA. Further, that those be issued with a great deal of care and caution and that the health systems agencies making recommendations to State agencies who issue those certificates-of-need should be doing their work with extreme care.

I am not here to propose that every section of this country is in an over-bedded situation. It is not. I happen to live in one that is. There are a great many, in my own State, that can say part of my State is not in that situation.

In those areas where there is a need for new facilities, if your lending institutions—have, in their hands, a copy of the health systems plan, have in their hands a copy of the State health plans, have in their hands a copy of the State medical facilities plan, I cannot think of more useful tools for a financial institution to hold than something of that nature.

They know, no more than a certificate-of-need is issued in perpetuity, that an A&P store is open in perpetuity, a MacDonald's franchise is open in perpetuity, or a community swimming pool is filled in perpetuity.

Lenders take a risk based on what they consider rational costs for lending money—having devoted a good part of my life to the mortgage business.

I also believe that the care that we want to exercise, not only in issuing certificates of need, but in the appropriateness review on the other end, is that nobody is shooting from the hip. We are not issuing them (CON's) carte blanche. On the other hand, we are not here doing appropriateness review with any question in mind except what is the best service for the community.

I think that is where we are all trying to get, and it is as tricky a road as any of us have ever walked down. I do not think we have answers. We have a lot of good questions.

We just find in your bill that there are some potential good answers.

Mr. SATTERFIELD. I would agree with you that mortgage companies and people who lend money do accept rational risks, but the question that bothers me is how rational is this risk, and how firm is any health plan once it is adopted? It is subject to change any time the Secretary wants to issue new guidelines.

Ms. HANSON. Certainly, but as a lender, I would rather have an SHP with an annual implementation plan that is circulated community-wide once a year than have a 5-year projection of a new company based on the work of their CPA's that is never updated.

Mr. SATTERFIELD. Does it bother you at all that, under this Act, the Secretary of HEW can terminate the contract with an HSA any time he says they are not doing the job that they are supposed to do and can replace it with an entirely new one?

Ms. HANSON. Oh, heck yes, it bothers me a lot but, you see, I figure that if he is going to get up early to do that, we have to get up earlier to make sure it does not happen.

Mr. SATTERFIELD. I would like to know how you are going to keep it from happening.

Ms. HANSON. It is a tricky road, Congressman.

Mr. MATEK. In the matter of the national health planning guidelines we just recently had an example of the introduction of reasonableness into what had appeared to be an arbitrary process. Frankly, we are counting on the vigilance and sensitivity of Congress to keep it that way.

Mr. SATTERFIELD. Do you think the HSA's were responsible for that?

Mr. MATEK. No, sir, as a matter of fact, I do not. And if HSA's do not soon learn how to do it, we probably do not deserve to have it done.

Give us awhile. We have only been here for 1 year.

Mr. SATTERFIELD. I do not mind giving you all awhile, in fact I am all for the HSA's. My problem is with the Secretary of HEW. I do not think he should have all of the control and the power that he has in this act, and it bothers me no end.

Ms. HANSON. Well, now, I agree with some of what you are saying and I agree with some of that power, but as I look at the system, there is a lot about that system that troubles.

There is a system of checks and balances in there. Admittedly, he is the bottom line. All right? That does not thrill me to death.

Mr. SATTERFIELD. Well, I do not think you can have checks and balances when he makes the ultimate decision.

Ms. HANSON. Well, he makes the ultimate decision assuming that some point along the way, as the decision is made, somebody does not say, "Fine, let's proceed." He makes the final decision based on a number of other things either not happening or somebody objecting to a number of other things.

Mr. SATTERFIELD. Still at his own discretion.

Ms. HANSON. Oh, sure. But I signed a contract that I signed with my region to run my HSA and get federally funded for that grant year. We meet each other periodically to see how the HSA is coming and how HEW is coming and if everybody is happy.

Now, if I know I am not meeting our requirements, I guess I have to assume I could get cleaned out at some point. I just think there are rules along there.

I agree with you that that is a problem, but somebody has to be the bottom line.

Mr. MATEK. I would like to just add to that it is far better to have the Secretary, who represents one target, have that responsibility—and I think it is a severely compromised responsibility already—than to have 50 separate people—the Governors—with that responsibility and not be able to get at them in any consistent way.

Ms. HANSON. Hear, hear.

Mr. SATTERFIELD. Well, let me ask you this one question. My time is running out, and I will return to my remaining questions later, but in that line, you made the statement that the certificate-of-need requirement, in and of itself, could freeze the system.

Mr. MATEK. I think it does.

Mr. SATTERFIELD. All right, now. Especially this is true, it seems to me, where the Secretary of HEW proceeds to issue guidelines which he says have to be met.

In that context, should HMO's be excluded from certificates-of-need and should they be excluded from any imposition of limitations on their construction funds?

Mr. MATEK. Not totally, Congressman. I believe that the way your bill has been drafted to cover HMO's exactly in the same terms as any other health institution is the appropriate, balanced, way to deal with that.

Mr. SATTERFIELD. I am referring, of course, to testimony yesterday morning by the Assistant Secretary of HEW when he made these two proposals. You do not agree with those proposals?

Mr. MATEK. We would not agree with them.

Mr. SATTERFIELD. Thank you very much.

Mr. Chairman, I will reserve the balance of my questions.

Mr. ROGERS. Mr. Florio?

Mr. FLORIO. Thank you very much, Mr. Chairman.

I would like to thank both witnesses for their comments.

Ma'am, you said something about the fact that the HSA is primarily designed to deal with some controversial issues. I wonder if you feel that the ability to deal with those issues will be inhanced by one of the provisions in the proposed bill that mandates that prospectively 25 percent of the board should be composed of local elected officials.

Ms. HANSON. I made a comment—it is in our testimony, but I did not read it. I think personally, and I know the association is in favor of total participation from every segment of the community.

I served in an HSA from the day it was started, that allowed up to one-third of our board membership to be elected officials. As many as 10 of the 30, one-third. And to this date, I have had two serve and one removed from the SHCC for cause for nonattendance.

To say that any segment of the community is more or less valuable to an HSA is just simply a misdefinition. I think the consumer-provider balance is wise and I think it is extraordinarily successful.

If, among those consumers and providers, you happen to have people who fall under one category or another who are elected officials, I am absolutely delighted to have them there and I think they belong there. I think they are as much a part of my community and your community as anybody else, but to mandate that a) either they be outside the count of consumer and provider is mad. I mean, they have to be something. Everybody has to be something.

Mr. FLORIO. This provides that the local officials will come from the provider sector.

Ms. HANSON. Well, you see, I disapprove of that, too. I do not know how you can get more people out of 51–49 percent, but every provider participant I have had on my board has brought another facet of my community into our deliberations that I would have never known before. At the end of 2 tough years we sat down, last Tuesday at our annual meeting, and said to each other, "I do not care what anybody says, you are not as bad as I thought you were."

We have had 2 years of opportunities for us to learn more about provider perspectives and for them to learn more about consumers. We cannot take away 25 percent of those providers—we now have about 50 groups who are clamoring because they do not feel that they can get representation in that 49 percent. Fourteen people are not very many people representing the whole breadth of the provider community.

Mr. FLORIO. I understand that.

Ms. HANSON. I understand the elected officials problem, the providers, all of us ultimately are purchasers of health care. But I am an amateur. I am worth exactly what you are paying me, but I sure need

to hear from the provider who is out there doing whatever it is I am trying to make judgments for. That is the only person I can learn from.

Mr. FLORIO. I assume that means that you do not think the——

Ms. HANSON. I do not see how it is workable, Congressman. If you could make it work somehow, but I do not see how.

Mr. FLORIO. You are not going——

Ms. HANSON. Let them be providers or consumers. The Mayor of Kansas City, Missouri is a physician. If he wants on my board, I have a double threat there. Terrific.

You see?

But I cannot give up slots to put in people just because they are elected officials.

Mr. FLORIO. The answer is that you are not enthused about that provision in the bill?

Ms. HANSON. I just find it unworkable. I will not say I am not enthused. How does it work?

Mr. FLORIO. We each get 5 minutes to ask questions.

Ms. HANSON. I'm sorry.

Mr. FLORIO. If I might ask the gentleman a question with regard to modernization moneys. We had people here from HEW yesterday and they said that their interpretation of the law is that the HSA's are required to provide their opinions in the sense of advisory opinions as to the desirability of modernization or rehabilitation grants.

Is that your understanding of what your mandate is? Advisory opinions as opposed to requirements to approve?

Mr. MATEK. Yes, sir, that is the way that the certificate of need process is written. The agency recommends and the State decides.

However, what we want to see firmly established is that the State be committed and obliged to not make a decision which contradicts the recommendation of the HSA unless they have good, documented reasons.

Mr. FLORIO. Let me distinguish between certificate of need and applications for modernization grants.

Mr. MATEK. Yes, sir. I believe that applications for modernizations or renovations or replacements should be part of the certificate of need proposal.

Mr. FLORIO. You believe that, but that is currently not the case. Is that your interpretation?

Mr. MATEK. In California, they have tied it in. I do not believe it is that way nationwide. It is a separate issue in other States. I think it should be tied together.

Mr. FLORIO. Lastly, let me ask a question. You gave an example of some of the ingenious devices that are being arrived at to circumvent certificate of need. Something that is happening in areas that I am familiar with, particularly in radiology departments, hospitals are contracting with radiologists for hospital operated faciltes to be controlled by, and operated by, the radiologists on a contractual basis with a percentage fee being charged. The radiologist group will operate the radiology department of the hospital on a percentage or a cost-plus basis.

Are you familiar with this approach, and if you——

Mr. MATEK. I am not only familiar with it, sir, but in our area, radiologists pay premiums of $50,000 to $100,000 to get these contracts.

Mr. FLORIO. Do you have any thoughts as to how that problem can be dealt with?

Mr. MATEK. We are pleading in California to make it required that all contracts between physician groups and hospital institutions be made part of the public record and be subject to scrutiny by HSA's and the State. Without that kind of disclosure, the cost containment efforts which are part of our priorities are going to be constantly subverted by practices which are not exposed to the light of day.

Mr. FLORIO. It would appear on the basis of some due process provisions, if the Congress were to even consider that, such rulings would have to be prospective. Do you have any suggestions as to how one would be able to review contracts that are already entered into?

Mr. MATEK. You could just put in your bill that part of the authority of the HSA, or perhaps the State, since they have more regulatory authority, is to require institutions as part of the review process to disclose all existing contracts and relationships which materially affect the rates they charge.

Now, you might be able to do that more effectively through the rate review and rate regulation mechanisms than the HSA mechanism, but to the extent that HSA's examine certificates of need and to the extent that HSA's are responsible for financial feasibility analysis, I believe HSA's must have the right, as a precondition of doing our job well, to look at data on contractual relationships.

Mr. FLORIO. Let me take a moment here to ask one more question, because it is fairly significant.

There is not going to be that much more new construction money. The modernization moneys, and the rehabilitation moneys are going to be forthcoming, and that is a very effective vehicle for reviewing the internal operations of hospitals, contracts such as we just referred to. Would you think it feasible that the HSA's, if given the opportunity to sign off, approve, review, make recommendations, could evaluate some of these factors such as contracts in terms of making recommendations to HEW for approval of modernization monies?

Do you think that might be a vehicle to provide some internal management review?

Mr. MATEK. Yes, Congressman, it would significantly enhance the ability of the system at all levels to deal with the issues.

Mr. FLORIO. Thank you very much.

Mr. ROGERS. Thank you.

Mr. Preyer.

Mr. PREYER. I have no questions at this time.

Mr. ROGERS. Mr. Waxman.

Mr. WAXMAN. I have none at this time either.

Mr. ROGERS. All right.

There may be questions submitted that we would like answered for the record. I have some that, because we have such a heavy schedule of witnesses, I will submit some questions to you.

Your testimony has been most helpful. The committee will probably be in touch with you to get some of your advice as we proceed.

Ms. HANSON. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you for being here. You have been most helpful.

Ms. HANSON. Thank you, gentlemen.

Mr. MATEK. Thank you, Mr. Chairman.

Mr. ROGERS. The next witnesses will compose a panel on excess hospital capacity. Mr. J. K. Shelton, who is manager, of the employee insurance department, finance staff, of the Ford Motor Co., accompanied by Mr. Leo Greenawalt, vice president of governmental affairs, Michigan Hospital Association; Mr. Simon Gottlieb, who is executive director of the Greater Detroit Hospital Council; Mr. Thomas E. Greene III, Hospital Financing Study Group, accompanied by Mr. Thomas H. Quinn, general counsel, Hospital Financing Study Group.

We welcome each of you to the Committee. We would be pleased to receive your statements. Each of your statements will be made a part of the record in full, and if you could highlight the major points for the Committee, it would be helpful.

I might say, Mr. Quinn, the committee is glad to see you back before it again.

Mr. QUINN. Thank you.

Mr. ROGERS. You may proceed.

Mr. SHELTON. Mr. Chairman, I have filed a longer statement for the record——

Mr. ROGERS. Excuse me.

Could we have order, please?

You may proceed.

Mr. SHELTON. Mr. Chairman, I have filed a longer statement for the record [see p. 264], but, as requested, I have a shorter version which I believe has been distributed for your convenience.

Mr. ROGERS. Thank you. That will be helpful.

STATEMENTS OF JACK K. SHELTON, MANAGER, EMPLOYEE INSURANCE DEPARTMENT, FINANCE STAFF, FORD MOTOR CO., ALSO ON BEHALF MICHIGAN COST CONTAINMENT COALITION, ACCOMPANIED BY LEO GREENAWALT, VICE PRESIDENT FOR GOVERNMENTAL AFFAIRS, MICHIGAN HOSPITAL ASSOCIATION; AND SYMOND R. V. GOTTLIEB, EXECUTIVE DIRECTOR, GREATER DETROIT AREA HOSPITAL COUNCIL; AND THOMAS E. GREENE III, HOSPITAL FINANCING STUDY GROUP, ACCOMPANIED BY THOMAS H. QUINN, GENERAL COUNSEL

Mr. SHELTON. My name is Jack Shelton. I am manager of the Employee Insurance Department of Ford Motor Co. I am also chairman of the Michigan Cost Containment Coalition. With me is Mr. Leo Greenawalt, vice president for Governmental Affairs of the Michigan Hospital Association.

I am here today, at the request of the subcommittee, to describe a Michigan Legislative initiative designed to reduce excess hospital capacity and thereby help contain health care costs.

The impact of health care costs on the Ford Motor Co. and the Michigan State government, which led to the development of this

initiative, is described in greater detail in the statement I filed with the committee.

The coalition is the result of the Michigan legislators concern over medicaid program costs and a desire to work with business and labor on mutually advantageous cost containment legislative initiatives.

Represented on the coalition are the major automobile companies, the Michigan State legislature, Blue Cross-Blue Shield of Michigan, United Automobile Workers and the executive branch of the Michigan State government.

Following analysis of the cost problem, the coalition concluded that a major reason for rapidly escalating health care costs in Michigan was the existence of significant excess hospital capacity. The State Office of Health and Medical Affairs estimates that Michigan will have almost 6,500 excess, non-Federal acute care hospital beds by 1982. This represents over 16 percent of the total State bed supply.

Between 1968 and 1976, the average hospital occupancy rate in Michigan declined from 82 percent to 75 percent and on a typical day, one bed out of four is empty.

Despite enactment of certificate of need legislation in 1972, data indicates the situation is not improving. The acute care bed to thousand population ratio in Michigan has remained unchanged at 4.4 since 1968.

Excess hospital beds add to unnecessary health costs in two ways. First, they contribute to over-utilization of services, as hospitals and hospital-based physicians strive to fill the empty beds.

Second, empty beds are expensive to maintain.

These hospital costs are unnecessary and result in reallocations of resources from other economic sectors—education, for example, and possibly a diversion of health expenditures from areas having a greater impact on health status.

The coalition decided that its initial efforts should focus on the elimination of Michigan's excess hospital capacity.

To address the problem of excess hospital capacity, the coalition, working with representatives of the Michigan Hospital Association, drafted House bill 4491—we have also made copies of that bill available for your review.

In summary, the bill provides the following. The statewide health coordinating council approves guidelines and criteria for identifying excess hospital bed capacity and developing and approving bed reduction plans. Based upon these guidelines and criteria, a listing of subareas of the State with more than 25 excess hospital beds is compiled. With exceptions under certain defined instances, a moratorium on new certificates of need is imposed in the overbedded areas only.

Health systems agencies responsible for over-bedded areas are required to develop a 5-year hospital-specific bed reduction plan. To assure that the plans developed are cost-effective, the HSA's must consider actions to reduce capacity in the following order.

First, mergers or consolidations of two or more institutions.

Second, closure of an entire hospital.

Third, consolidation of major clinical services among two or more hospitals.

Fourth, closure of nursing units within a hospital.

The emphasis of the bill is on reducing excess capacity through mergers and consolidations of hospitals. Closure can be considered only after all reasonable efforts to merge are fully exhausted.

Bed reduction plans are submitted to the SHCC for approval. Following approval of bed reduction plans, the moratorium on new certificates is lifted, and certificates of need are issued consistent with the approved plans.

The maximum period of the moratorium is 14 months.

The coalition recognized that planned reductions in hospital capacity faced two major obstacles: Displacement of employees and coverage of hospital capital indebtedness. These issues were not resolved by the coalition because of their complexity and the time constraint on the development of the bill.

Therefore, a provision was added to require the Governor to appoint a blue ribbon task force to fully explore and make recommendations on the legal, financial and unemployment problems associated with a reduction in hospital capacity.

Development of plans and resolutions of these issues will be done concurrently.

The bill throughout its development has had the support of major interests including the auto companies, the UAW, the Michigan Hospital Association, the Michigan Osteopathic Hospital Association, the Greater Detroit Hospital Council, Blue Cross-Blue Shield of Michigan, the AFL–CIO, the Michigan Insurance Commissioner, the State Health Planning and Development Agency, the Michigan Department of Public Health, the statewide Health Coordinating Council, the Michigan Association of Health Systems Agencies Executive Directors, and Governor Milliken.

There are several reasons explaining the wide and bipartisan support of the bill. The Michigan Hospital Association provided leadership for its membership by participating in its development. Without their responsible support, I am sure that our efforts would not have been successful.

The bill emphasizes a gradual, orderly achievement of bed targets in subareas significantly over-bedded, exempts the majority of rural areas since they have less than 25 excess beds, and places more control and authority with the HSA.

Its emphasis is on voluntary consolidation of hospital capacity and the only sanction is a future denial of certificates of need to hospitals not in compliance with the approved bed reduction plans.

Mr. Chairman, the coalition was encouraged to learn that your subcommittee sponsored an amendment to the President's cost containment bill which provides Federal grants for payment of outstanding debt of closed hospital and financial incentives for reduction of hospital capacity.

Resolution of the capital indebtedness issue is a prerequisite for the development of stronger bed-reduction sanctions.

[Testimony resumes on p. 276.]

[Mr. Shelton's prepared statement follows:]

STATEMENT OF JACK K. SHELTON, MANAGER, EMPLOYEE INSURANCE DEPARTMENT, FORD MOTOR COMPANY, ON BEHALF OF FORD MOTOR COMPANY AND MICHIGAN COST CONTAINMENT COALITION

Mr. Chairman, my name is Jack Shelton. I am manager of the Employe Insurance Department of Ford Motor Company. In this position, I am responsible for the purchase and financial administration of the Company's employe insurance programs. I am appearing here today, at the request of this Subcommittee to discuss the impact of health care cost escalation on Ford Motor Company and to describe a Michigan legislative initiative designed to reduce excess hospital capacity and thereby help contain health care costs.

My appearance is on behalf of Ford Motor Company and the Michigan Cost Containment Coalition. The latter group includes representation from business, labor, and government interests. I will discuss in more detail its membership and activities later in my remarks.

My testimony will cover five principle areas: (1) history of Ford's health care benefit costs and their impact on the Company; (2) major causes of the health care cost spiral; (3) actions the Company is taking and/or supporting that may help contain health care costs; (4) development of the Michigan Cost Containment Coalition; and (5) proposed Michigan legislation to reduce excess hospital capacity drafted and supported by the Coalition.

Health Care Benefit Costs and Their Impact

As one of the nation's largest employers, Ford is a major purchaser of health care services for nearly one million hourly and salaried employes, retirees, surviving spouses, and their dependents. Ford provides one of the most complete benefit programs in the country. Benefits include hospital and physician services, prescription drugs, and dental, hearing, and vision care. Most of the primary health coverages are "first dollar" benefits; however, employes share in the cost of dental, hearing, vision, out-patient psychiatric care, and prescription drugs.

Since 1965, health care costs for Ford Motor Company have doubled every five years, and this trend appears to be continuing. In 1965, Ford's health care bill totaled $68 million and averaged $350 per active employe. For 1977, our costs are estimated to be about $450 million, or about $2,000 per active employe.

There are several reasons for the dramatic cost increases which Ford has experienced -- inflation, higher utilization, new benefits, and an increased number of covered individuals -- but over two thirds of the increase since 1965 was due to inflation and higher utilization.

These cost increases must be recovered either through higher prices or improved productivity. Health care costs represented $22 per vehicle produced in 1965 and in 1977 they totaled about $120 per vehicle -- an increase of nearly $100 per unit produced. Diversion of funds to pay for such health care cost escalation reduces the Company's limited financial resources which are urgently needed for product and capacity programs -- both government mandated and those necessary to keep us competitive. Increases in prices can represent reduced volume potential and, therefore, reduced job potential -- so this diversion of financial resources is not without risk to our suppliers, employes, and the economy in general.

Causes of Cost Spiral

The causes of the escalation of health care costs are varied and, in large part, rest outside the control of Ford Motor Company. We believe major problems are:

- One -- lack of sufficient incentives to contain costs - The health care system tends to absorb all the dollars that are made available to it. This system is characterized by consumers and providers who are conscious of quality but insensitive to costs; and facilities which are encouraged to provide the most sophisticated, specialized, and technological services available. Fee-for-service and cost plus reimbursement policies remove financial considerations from health care decisions and there exist no incentives to weigh medical benefits against their costs.
- Two -- over-capacity of health delivery facilities - In most metropolitan areas, there exist excess hospital capacity, excessive amounts of diagnostic and laboratory equipment, and a surplus of hospital-based specialty physicians.

. Three -- resource distribution - Distribution of both facilities and manpower is a problem. While the large metropolitan areas have excess resources -- many smaller communities and rural areas are deficient in both categories.

. Four -- over utilization - There appears to be a substantial amount of over-utilization of services -- both consumer and provider induced. There is evidence suggesting that too much surgery is being practiced, too many drugs are being dispensed, people are being hospitalized when out-patient care would be medically appropriate, and too many outmoded procedures are being used.

. Five -- quality of care - It is an unfortunate fact, but there are facilities providing services at volume levels which are inefficient and could jeopardize quality of care.

. Six - poor management - The management skills that are applied to the delivery of health care -- in hospitals, in clinics, and in private offices -- must be upgraded and made more productivity-oriented, and

. Seven -- consumer over expectation - In recent years, most Americans have developed higher and more unrealistic expectations of what the health care system can or should accomplish. These expectations have led to an over-reliance on medical intervention for maintenance of health rather than the practice of a healthy lifestyle. We believe the major improvements in health status of Americans can be achieved best and most economically through changes in lifestyle and behavior rather than from increased medical care.

We recognize that each of these areas is complex, and there are no simple, ready-made solutions. However, because of the seriousness of the health care cost spiral, we believe that all interests -- business, labor, government, providers, and consumers -- must accept some responsibility for the problem and for the design and implementation of innovative solutions.

Actions the Company is Taking or Supporting

Because of our cost experience, Ford Motor Company has significantly increased its involvement in health care cost containment initiatives. In those areas where it can impact the problem directly, the Company has initiated new programs and strategies. These include:

- Benefit Design - Benefit plans are being reviewed and, where possible, designed to provide only for medically appropriate care and to discourage unnecessary utilization and expenditures. Examples include the introduction of co-payments for new benefits and outpatient coverage of procedures that previously only were covered in hospitals.
- Preventive Care - The Company has established pilot programs to assist employes in identifying and managing health problems. Programs include Cardiovascular Risk Intervention, Substance Abuse Counseling, and Hypertension Screening.
- Delivery Efficiency and Appropriateness of Care - The Company and UAW are jointly working with insurance carriers and providers to increase the delivery system's cost efficiency and to improve the appropriativeness of the care being provided. Joint projects agreed to in our 1976 agreement with the UAW include utilization review programs, second opinion elective surgery, and model treatment screening. Ford also encourages the development of cost effective alternative delivery programs, including HMO's. Last year the Company commissioned a study to determine the feasibility of a new community-based HMO in Detroit. This report is being analyzed, by Ford and other business and provider interests, to determine if a new program can be launched.

In addition to these areas, the Company is involved in the following community efforts:

- Health Planning Agencies - Ford is represented on the local health systems agency for Southeastern Michigan and active on the Michigan Statewide Health Coordinating Council. We believe that involvement in state and local planning

agencies is one of the most productive ways for business to deal with health care cost problems. These agencies hold the key to cost-effective community management of the health care system.

. Hospital Trustees and Insurance Carrier Boards - The Company encourages its management to become involved as hospital trustees, and Ford management also are active on several Blue Cross-Blue Shield and other carrier boards. Memberships on these boards provide opportunities to exercise leadership in developing productive cost containment initiatives benefiting the whole community.

In addition to these key areas, Company representatives are active on several state and national advisory groups. We are heavily involved with the Michigan Cost Containment Coalition responsible for developing joint private-public sector programs to deal with Michigan's health care cost problems. This Coalition has drafted legislation in Michigan which is designed to address a priority cost containment problem -- excess hospital capacity. I now will describe the development of this Coalition and the legislation it has drafted.

Development of the Michigan Cost Containment Coalition

You are familiar with national statistics documenting the health care cost problem; and earlier in my presentation I reviewed the impact of escalating costs on Ford Motor Company. The Coalition is the result of the Michigan Legislature's concern over Medicaid program costs and a desire to work with business and labor on mutually advantageous containment initiatives.

Over the last eight years, the Michigan Medicaid Program has been confronted with higher costs for health services, an expansion in benefits, and until last year, an increase in the number of Medicaid eligibles. As a result, while national expenditures between 1970 and 1976 increased by 100%, Michigan Medicaid expenditures increased by 225% -- from $212 million to $690 million. The cost of the program for fiscal year 1978 is projected to be $795 million. These increases, especially during the 1974 and 1975 recession years, imposed serious fiscal problems on state

government. During this period, one out of every four new state budget dollars was appropriated for the Medicaid program.

State legislators, through their efforts to deal with the cost escalation -- including curtailing of benefits and strict utilization review -- learned that focusing on cost containment only within the Medicaid program is not effective. Modifications in the Medicaid program alone -- although they might reduce costs to the state government -- do not address the root causes of the health care cost problem. Often such efforts tend to shift costs to others and penalize both efficient and inefficient providers. Therefore, representatives of the legislative and executive branches of Michigan government concerned about the Medicaid budget felt it imperative to attack the causes of the increases in the total health system costs.

Early in 1977, these representatives of state government began meeting with auto industry and labor representatives. This group shared similar concerns and there was a strong feeling that, working together, common strategies for medical care cost containment could be identified. The result of those initial meetings was the formation of a Cost Containment Coalition composed of representatives of the major automobile producers, the Legislature, Michigan Blue Cross-Blue Shield, United Auto Workers, and the Executive branch of Michigan's state government. I am the chairman of this Coalition.

Priority was given by the Coalition to identifying health system problem areas contributing significantly to unnecessary costs in Michigan which could be addressed realistically in a timely fashion at the state level. Following analysis, it was unanimously decided to concentrate on hospital costs -- the most rapidly rising component of health expenditures. Between 1960 and 1976, U.S. hospital expenditures increased from 33% to almost 40% of total health care expenditures.

The Coalition concluded that one of the reasons for rapidly increasing hospital costs in Michigan was the existence of significant excess hospital capacity. The state Office of Health and Medical Affairs estimates Michigan will have almost 6,500 excess non-federal acute-care hospital beds by 1982 -- this represents over 16% of the total bed supply. Evidence of the excess is reflected in state hospital occupancy rates which declined from 82% in 1968 to 75% in 1976. This compares with an accepted standard of 85% and means that on the average day one bed out of every four is empty in Michigan. Despite the enactment of certificate of need legislation in 1972, data indicates the situation is not improving. The acute care bed ratio per thousand population in Michigan has remained unchanged at 4.4 since 1968.

Excess hospital beds add to unnecessary costs in two ways. First, they contribute to overutilization of services as hospitals and hospital-based physicians strive to fill the empty beds. Second, empty beds are expensive to maintain. It is estimated that the cost to operate an empty bed is from 50% to 70% of the cost of a full bed. These hospital costs are unnecessary and result in a reallocation of resources from other economic sectors -- education for example -- and possibly a diversion of health expenditures from areas having a greater impact on health status. Although there is disagreement on the exact cost of Michigan's excess hospital capacity, there is a concensus among all major interests in Michigan that significant savings can be realized if hospital capacity is reduced to appropriate levels in a cost effective manner. The Coalition decided that its initial effort should focus on the elimination of Michigan's excess hospital capacity.

It should be emphasized that the issue of excess capacity, while extremely important, is not the only problem being addressed in Michigan. As indicated earlier in my testimony, Ford, and other members of the Coalition, are involved in a broad spectrum of cost containment activities. The work of the Coalition to address excess capacity is designed to complement these initiatives. For example, Michigan Blue Cross-Blue

Shield has had a concurrent utilization review program in effect for over one year, and on January 1 of this year implemented a new hospital prospective reimbursement program and a new incentive reimbursement program for physicians.

Proposed Michigan Legislation

To address the problem of excess hospital capacity, the Coalition, working with representatives of the Michigan Hospital Association, drafted House Bill 4491 -- an amendment to the State Certificate of Need Law. In summary, this bill requires the development of hospital-specific bed reduction plans for such areas of the state that are significantly overbedded. The plans will provide for the adjustment of hospital capacity to the appropriate level within five years. Following approval of these plans, certificates of need will only be issued consistent with the bed reduction plans.

The Bill is attached to this testimony for your information and the following summarizes key provisions:

. The Statewide Health Coordinating Council (SHCC) approves guidelines and criteria for identifying excess hospital bed capacity and developing and approving bed reduction plans.

. Based upon these guidelines and criteria, a listing of sub-areas of the state with more than 25 excess hospital beds is compiled by the Michigan Department of Public Health.

. With exceptions only under certain defined instances (including mergers and emergencies), a moratorium on new certificates of need is imposed in the overbedded areas only.

. Health Systems Agencies responsible for overbedded areas are required to develop five-year hospital-specific bed reduction plans. To assure that the plans developed are cost effective, HSA's must consider actions to reduce capacity in the following order: (1) mergers or consolidation of two or more institutions; (2) closure of entire hospitals, (3) consolidation of major clinical services among two or more hospitals, and (4) closure of nursing units within a hospital.

The emphasis of the bill is on reducing excess capacity through mergers and consolidation of hospitals. Closure can be considered only after all reasonable efforts to merge are fully exhausted.

. Bed reduction plans are to be submitted to the SHCC for approval. If a bed reduction plan for an overbedded area is not developed by the HSA or SHCC, a plan must be developed by the Michigan Department of Public Health. Following approval of bed reduction plans, the moratorium on new certificates is lifted and certificates of need are issued consistent with the approved plans. The maximum period of the moratorium is fourteen months; in most areas it will be lifted in eleven months, if not sooner.

The Coalition recognized that planned reductions in hospital capacity face two major obstacles -- displacement of employes and coverage of hospital capital indebtedness. These issues were not resolved by the Coalition because of their complexity and the time constraints on the development of the bill. Therefore, a provision was added to require the Governor to appoint a Blue Ribbon Task Force to fully explore and make recommendations on the legal, financial, and employment problems associated with a reduction in hospital capacity. Although recognizing the seriousness of these obstacles, the Coalition unanimously agreed that postponement of the development of bed reduction plans until these issues are resolved is inadvisable because of the long lead time required by the HSA's for plan development. Development of plans and resolution of these issues will be done concurrently.

The bill was submitted in the Michigan House of Representatives and referred to the Appropriations and Public Health Committees. Both committees reported it out to the floor with a recommendation for passage and it is anticipated that the full Michigan House will act on the bill in the near future. Following passage in the House, the bill will be introduced in the Michigan Senate and hopefully will be enacted in the spring of this year.

The bill, throughout its development, has had the support of major interests including Ford Motor Company, General Motors, Chrysler Corporation, United Auto Workers, Michigan Hospital Association, Michigan Osteopathic Hospital Association, Blue Cross and Blue Shield of Michigan, AFL-CIO, Michigan Insurance Commissioner, State Health Planning and Development Agency, Michigan Department of Public Health, Michigan Statewide Health Coordinating Council, and the Michigan Association of HSA Executive Directors. Governor Milliken, in this year's State of the State Message, addressed the problem of excess capacity. He said in part, "...decreasing the number of hospital beds would have a significant impact on the cost of health care in the state ... I have endorsed (H.B. 4491). The bill will allow for an orderly reduction in the number of excess beds over five years ... I support early passage of this much needed legislation ..."

There are several reasons which explain the wide and bipartisan support of this legislative initiative. I would like to review them since they may have implications for national policy.

1. The Michigan Hospital Association, rather than responding defensively to the issue, provided leadership for its membership by participating in the development of the bill. Without their responsible support, I'm sure our efforts would not have been successful.
2. The extent of hospital overbedding in Michigan is well documented and it is acknowledged that excess hospital capacity is expensive. This bill establishes the best planning process for addressing the problem.
3. The plans developed under the bill require a gradual, orderly achievement of bed targets over a five-year period. The approach is evolutionary and not revolutionary.
4. The bill does not specify the closure of any hospital or unit. Rather, it establishes a reasonable mechanism for local communities to develop plans for eliminating excess hospital capacity.

5. Sub-areas of the state with less than 25 excess beds are not subject to the legislation. This provision effectively exempts the majority of the rural areas of the state while maintaining emphasis on those areas where significant excess capacity exists.
6. The bill does not provide for the delicensing or decertification of any hospital. Its emphasis is on the voluntary consolidation of hospital services and bed capacity. The only sanction in the bill is the future denial of certificates of need to hospitals out of compliance with approved bed reduction plans.
7. The bill places more control and authority at the regional planning level than existing policies.
8. Implementation of the bill will strengthen the hospital system. Alternative approaches often penalize all institutions -- including those delivering high quality and efficient care.
9. A rational distribution of facilities may promote a rational distribution of manpower. Surplus facilities in urban areas complement manpower maldistribution.
10. The bill is seen as an alternative to additional, often inflexible, Federal controls.

The Coalition was encouraged to learn that this subcommittee sponsored an amendment to the President's cost containment bill which provides federal grants for payment of outstanding debt of closed hospitals and financial incentives for the reduction of hospital capacity. Resolution of the capital indebtedness issue is a prerequisite to the development of stronger bed reduction sanctions such as decertification or delicensing. If, in your judgment, it becomes necessary to mandate stronger Federal control programs, the Coalition would urge the inclusion of exemptions for states which can demonstrate their ability to contain costs. You have the difficult and necessary tasks of balancing stronger federal incentives

and controls against the risk of destroying local and state initiatives. I would caution you to proceed carefully because I do not believe that the long-term solution to the cost problem can be mandated from Washington. We need to foster increased state and local awareness of the problems and motivate states to develop aggressive initiatives that are responsive to local problems and interests.

Conclusion

In conclusion, Ford Motor Company has been adversely affected by health care cost escalation and has allocated additional resources to work with appropriate parties toward reasonable solutions. The Michigan Cost Containment Coalition, which I believe is a unique group effort, demonstrates the extent of private industry, labor, and state government concern with health care costs and the problem of excess hospital capacity. It represents an example of how public and private interests can work together to design effective solutions to health care problems. I would hope that any Federal legislation that may be adopted in this area would complement and support such actions rather than displace them.

Mr. ROGERS. Thank you, Mr. Shelton, for your statement. The ideas that you are developing in Michigan will be helpful to the committee in its consideration of this problem, and I want to commend the Hospital Association, as well, of your state for asserting leadership along with all of you in the coalition.

Mr. Gottlieb?

STATEMENT OF SYMOND R. V. GOTTLIEB

Mr. GOTTLIEB. Thank you, Mr. Chairman. My name is Symond Gottlieb. I am the executive director of Greater Detroit Area Hospital Council. We furnished a written statement and I will just try to summarize it briefly, but even the written statement, I should note, is based on a very large study and report that the Hospital Council finished recently, with the title, "Excess Hospital Capacity, a Strategy for Reduction."

In that study, we attempted to look at a great many of the factors that had to be faced from a practical standpoint if we were going to do something about reducing excess capacity, current excess capacity, within a reasonable timeframe.

I cannot, obviously, go into the details of that 163 page report. Your staff has copies of it, and other copies would be available on request.

I would like to hit a few of the highlights, however. We did a survey, of course, of the current capital debt of hospitals and the capital structure of hospitals. We interviewed, in some depth, representatives of financial institutions and bond counsel and other kinds of people with knowledge of that kind of subject matter.

We interviewed corporation lawyers and constitutional lawyers and a lot of other people who are heavily involved in this and we drew on our own experience over the past 21 years of being involved in areawide planning, an experience which includes, among other things, the direct or indirect involvement in closing 48 hospitals in southeastern Michigan since 1961.

In looking at all of that information, we classified the problems and identified what they are and tried to come up with a strategy for how you deal with them.

In looking at the problems, we looked at the problems of what you might call the sociopolitical problems first. The fact is that hospitals are supported by their communities for a lot of reasons. The people have identification with their hospitals. There are also economic reasons for supporting them.

For example ,if we would be able to close all of the excess beds in southeastern Michigan, we would lose about 11,000 jobs, and that is a political factor as well as an economic factor that you cannot overlook.

We looked at a great many of the professional kinds of considerations, the legitimate professional concerns, for example the role of a hospital board as trustees of the assets of the hospital. Hospitals, after all, have most of the characteristics of private corporations, even though they may be nonprofit corporations or instrumentalities of government. We looked at their legitimate concerns in arriving at decisions to reduce capacity.

We looked at the problems, the legitimate problems, that physicians have in terms of their staff appointments, their referral patterns and other factors that bear on their ability to practice medicine and raised some questions about that.

We looked at a great many of the legal issues that surround the problem of reducing capacity. They start, of course, with the idea that these are, in fact, private corporations that we are dealing with and they have certain rights under the law. We have questioned whether the Congress, or any other governmental unit, had the constitutional authority to take away what is basically a property right.

We questioned whether you can do it directly, through certificate of need or decertification process, or whether you can do it indirectly through the reimbursement process. At least those questions have to be considered.

And we looked at a great many of the financial considerations that would have to be taken into account in order to either justify constitutionally government action or, more importantly, to stimulate action by the private sector by appropriate pressure and support from both government and the reimbursement system.

And we identified not only longterm capital debt, we identified the problems of current equity and current fixed assets, the problem of satisfying current liabilities, the problem of the contingent liabilities faced by the operating institutions, the problems of the rights of employees and contractors and a host of other financial problems related to the process of corporate merger or closure or making alternate uses of facilities.

Most importantly, we looked at what we wanted to come out with after we finished this process successfully of capacity reduction, what were the kinds of health systems, in terms of not only cost containment but quality and accessibility and management, did we want to end up with when we finished?

Out of that came the idea of a policy framework that had to be included in any legislative approach, or planning approach; a series of priorities which have, as Jack has noted, been incorporated into the proposed Michigan law; and a series of methods by which, either through grants or the establishment of special funds or through some changes in the reimbursement system might handle some of these problems, the financial considerations.

Based on all of this, we would like to make some suggestions about how the problem might be handled if legislation were to be passed.

First, we think that the policy framework should be built into the legislation. It could probably be a modification of the statements of the second, fifth, and seventh priorities currently listed in Public Law 93–641, having to do with multiinstitutional arrangements and the comprehensive service programs of single organizations and shared service programs.

Second, we think that the priorities for action should be built into the legislation, that it should specify, as has this proposed Michigan legislation, corporate consolidation first, closure of hospitals second, and so forth.

Third, we believe that sanctions in the form of decertification of need or reimbursement penalties are unlikely to be effective. Serious

constitutional questions are raised by any attempt to take property or interfere with contracts for economic reasons through government action.

Even if the legal issues could be adequately resolved, in practice the political process severely limits the ability of bureaucrats to take such action. If adequately defined and rationally applied, the current appropriateness review mechanism is likely to be at least as effective as any governmental sanctions that can be devised, especially if supported by a program to resolve financial considerations.

Implementation of the appropriateness review mechanism must be accompanied by an extensive, continuous community and professional relations program designed to bring about public support for capacity reduction, or at least to reduce political opposition.

Fourth, sufficient funds must be made available to stimulate voluntary action to reduce capacity or to reduce the likelihood of successful constitutional challenges to government action. Funds required will vary with each situation and with the approach developed to reduce capacity. Such funds may be necessary to satisfy current, long-term debt to purchase equity or fixed assets, to satisfy current liabilities, to satisfy employees rights, especially unemployment compensation and accrued and unfunded benefits, and contractors rights, and to cover contingent liabilities, and to cover expenses for the consummation of mergers and the costs of developing alternate uses of facilities.

Surviving hospital corporations after mergers, or partial closures, must also have some assurance of maintaining adequate working capital and cash flow for a transitional period after capacity is reduced. Such funds can be furnished through grants or loans or flexible applications of reimbursement systems and through special relief from ceilings or payment limitations.

Fifth, in developing plans designed to identify the amount and location of excess capacity and the priorities for action, it is unwise to require the health systems agency or the State agency to provide institution-specific designation of corporate consolidations or closures. Unless there is very strong public, professional, and political support for capacity reduction, such designations are likely to be so politically volatile that they can destroy the agency.

Perhaps even more importantly, to the extent that an effective program requires voluntary action, opportunities must be provided for negotiation and trade-off which would be lost by institution-specific designation. Plans developed by such agencies can clearly and effectively indicate the direction of the capacity reduction program without impeding voluntary action.

For example, a proposal to reduce only medicare and medicaid reimbursement as a sanction might discriminate against inner-city hospitals with large volumes of indigent and elderly patients and actually force closure of the wrong hospitals.

I would be happy to answer any questions.

[Testimony resumes on p. 302.]

[Mr. Gottlieb's prepared statement and attachment follows:]

Sixth, all major purchasers and third-party financing agencies, private and public, have a large financial stake in the outcome of the capacity reduction program. Their participation in, and financial support of, the program in an equitable manner should be stimulated and encouraged. If financial sanctions are imposed, assuming it is desirable and could be done legally, care should be taken to insure that they support the policy framework in the priority system and that they can be equitably applied.

TESTIMONY BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE
ENVIRONMENT, HOUSE INTERSTATE
AND FOREIGN COMMERCE COMMITTEE

January 31, 1978

By Symond R. V. Gottlieb, Executive Director
Greater Detroit Area Hospital Council, Inc.



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My name is Symond R. V. Gottlieb. I am the Executive Director of the Greater Detroit Area Hospital Council, a community service organization, serving the 4,800,000 people in the seven counties of southeastern Michigan. In terms of continuous service, our organization is the oldest areawide health planning agency in the United States. Our goal for the past twenty-one years has been to improve the management of community health resources for the benefit of all of the people of southeastern Michigan.

My purpose today is to discuss the problem of current excess hospital capacity and what might be done about it. Our organization is concerned about many aspects of P. L. 93-641 and its administration and about all aspects of H. R. 6575 (especially Title II and Title III); but I believe I can be most helpful today if I concentrate upon the capacity reduction issues.

We recently completed a major paper on the subject, "Reduction of Excess Hospital Capacity: A Suggested Strategy for Action".

Including appendices it is 163 pages in length. Copies were distributed last month to your staff, and additional copies are available on request. Obviously, I am not going to read the entire paper -- but I would like to summarize some of its more important features for you this afternoon.

In February, 1977, the Greater Detroit Area Hospital Council agreed to conduct a survey of current long-term capital debt in southeastern Michigan hospitals for the Michigan Office of Health and Medical Affairs and to suggest methods of satisfying such debt if a program to reduce excess hospital capacity were undertaken by the state. With excellent cooperation from almost all of the hospitals in the seven-county area, the survey was quickly completed. Intensive and extensive interviews were carried out with representatives of major financial institutions in Michigan and New York, with attorneys specializing in capital financing issues, and with state officials concerned about the capital financing of hospitals. These interviews enhances our understanding of the complexities of capital financing, potential legal barriers to action, and possible methods which might be used to achieve the objective legally and in a manner which maintained good faith with the financial community.

It soon became apparent that a great many other issues were clearly interrelated with the questions concerning satisfaction of

capital debt. As the general problem of excess hospital capacity came into sharper public focus in Michigan and throughout the nation, a great many interested people began to suggest relatively simple solutions to the complex problem of excess capacity. During discussions with many such people who had come to believe that huge cost savings could be achieved if capacity were reduced, it became apparent that few of them had thought through the problems which would have to be resolved. Accordingly, we decided to broaden our exploration of the issues and to prepare a paper which attempted to set forth a complete strategy for action. Additional interviews were conducted with attorneys skilled in constitutional and corporate law and with others who have broad knowledge of several aspects of the problem. We also drew heavily upon the twenty-one years of experience in areawide health facilities planning by the Greater Detroit Area Hospital Council -- a period during which GDAHC participated directly or indirectly in bringing about the closure of about forty-eight hospitals with almost 3,600 beds either unilaterally, through corporate consolidation, or through relocation and replacement -- and upon the extensive experience of our entire staff.

The final paper was approved by our governing body on November 10, 1978, and is currently being published.

Summary

A carefully planned and vigorously implemented program to reduce excess hospital capacity would clearly make an important contribution to health care cost containment and to improved cost-effectiveness of the health care system. Such a program must be developed within the context of a sound policy framework which includes consideration of the size of the reduction in excess hospital capacity to be achieved, the methods of achieving that objective, the characteristics and contours of the health and hospital system to be in place after the capacity reduction program is successfully completed, and a strategy for action by the public and private sectors at the local, state, and national levels.

Attainment of the cost containment objective without equivalent concern for other health systems objectives revolving around quality, accessibility, organization, management, and comprehensiveness of health services is likely to prove to be self-defeating in the long run. For this reason, a methodology for capacity reduction which gives priority to corporate consolidations and unilateral closures of entire hospitals is not only likely to result in the greatest cost savings but is also most likely to achieve the other objectives, especially

if the characteristics of the future health and hospital system have been carefully developed as part of the policy framework.

The purposes of this paper have been to identify some of the obstacles which must be overcome if excess capacity is to be reduced within a reasonable time frame, to offer some concrete suggestions on methods of overcoming the principal obstacles, and to suggest a strategy and rationale for action. The elements of the suggested strategy include: adoption of an acceptable policy framework; development of relevant measures of capacity (since "bed need" is an extremely imperfect and misleading measure); adoption of a priority system for action; definition of the methods to be used to bring about action; identification of the practical problems which may be obstacles to action; development of the capability to resolve the practical problems; and, the creation of an orderly process to implement the strategy. A number of socio-political, professional, legal, and financial considerations which must be taken into account have been identified and a great many suggestions concerning those considerations have been made.

Capacity reduction can best be achieved through voluntary action, if such action is stimulated through an appropriate mixture of pressure and support by the reimbursement system and by government. Possible constitutional and legal constraints, coupled with the complexities

of the political process, suggest that the regulatory authority of government for this purpose is useful almost exclusively as a "lever" to expedite voluntary action. On the other hand, it is recognized that without external pressures and support it is unrealistic to expect expeditious voluntary action to reduce capacity in a rational manner.

If the suggested system of priorities for action is adopted, it is essential that decisions be based on a clear and defensible policy framework and upon careful and objective determinations of which facilities should be included in corporate consolidations or closed unilaterally. Methods are suggested for distinguishing those hospitals which should be encouraged to survive from those hospitals which should cease operations (at least as autonomous institutions).

The infrastructure of each community's support for its hospitals, coupled with the potential adverse economic impact on a community if hospitals are closed (e.g., the loss of jobs), often creates strong political opposition to proposals to reduce hospital capacities. These sociopolitical considerations can only be overcome if a broad community relations program is undertaken to improve acceptance of the concept and to justify each specific action. Similarly the legitimate concerns of hospital trustees and management (concerning management and cost effectiveness) and of physicians (concerning quality of care,

medical staff privileges, and their professional aspirations) may become obstacles unless an effective professional relations program is initiated and maintained.

Potential constitutional and legal constraints upon both government and voluntary action are described, but they require more definitive legal analysis before final conclusions can be drawn. The nature of hospital organizations as private corporations or instrumentalities of government (with some of the characteristics of charitable trusts) clearly have a bearing on the duties of their trustees and may determine the permissible parameters of government action. Constitutional prohibitions against interference by government with contractual obligations and against the taking of private property by government without (or even with) fair compensation may severely limit the role of government for this purpose. Indirect action by governmental reimbursement systems may be subject to the same constitutional constraints which could limit direct government action.

Not so surprisingly, the paper highlights the necessity "to spend some money to save more money", concluding that the advance commitment of funds to resolve financial issues could pay off at the rate of at least five dollars saved for every dollar committed in advance to the capacity reduction program. Financial considerations may include:

satisfaction of current long-term capital debt and current liabilities; the purchase of fixed assets and other equity; satisfaction of financial obligations to employees and contractors; payment for contingent liabilities; and needed "front-end" money. Funds must be made available to resolve these financial issues in order to expedite voluntary action, to bring government action within a constitutionally acceptable format, and to ensure that surviving corporations can fulfill their objectives after capacity is reduced. Several suggestions are made concerning potential sources of funds and administrative methods, including a variety of approaches to establishment of a special fund and a variety of approaches to establishment of a special fund and a variety of approaches to direct payment through the reimbursement systems.

In its conclusions the paper states that capacity reduction requires mutually supportive activity between the public and private sectors at the local, state, and national levels. Effective action cannot be achieved without the support of the political and legal systems, of business and labor leaders, of health care providers, and of others in each community whose interests are perceived to be affected. The conclusions also suggest (among other things) that the adoption of a capacity reduction program which creates more problems than it solves, which is likely to be harmful in the long run to the health interests of the total population, which is unworkable

in practice, or which is unenforceable is probably worse than no program at all.

Based on our analysis of the issues, we would make the following suggestions concerning any legislation which might be designed to bring about a reduction in current excess hospital capacity:

1. The policy framework within which the capacity reduction program is to be implemented should be stated in the legislation. We would suggest that such a policy framework could be developed easily with simple modifications in the statement of the second, fifth, and seventh priorities listed in Section 1502 of P. L. 93-641.

2. The priorities for action to reduce excess capacity should be spelled out in the legislation and other details of the legislation should clearly support the priorities. We would suggest language similar to that which is included in proposed legislation currently being considered by the Michigan legislature (H.B. 4491), as follows:

> " (7) In developing a plan to reduce excess hospital beds, the health systems agency or the council (SHCC) shall first consider the possibility of consolidation of 2 or more hospitals in the subarea. If consolidation is inappropriate or insufficient for the plan, the closure of hospitals

shall next be considered. If closure of a hospital is inappropriate or insufficient for the plans, the consolidation of a major clinical services among 2 or more hospitals shall next be considered. If the consolidation of major clinical services is inappropriate or insufficient, the closure of nursing units within a hospital shall next be considered. The council (SHCC) shall not approve a plan which does not address the priorities described in this subsection."

3. Sanctions in the form of decertification of need or reimbursement penalties are unlikely to be effective. Serious constitutional questions are raised by any attempt to take property or interfere with contracts for economic reasons through government action. Even if the legal issues could be adequately resolved, in practice the political process severely limits the ability of bureaucrats to take such actions. If adequately defined and rationally applied, the current appropriateness review mechanism is likely to be at least as effective as any governmental sanctions which can be devised, especially if supported by a program to resolve financial considerations. The implementation of the appropriateness review mechanism must be accompanied by an extensive continuous community and professional relations program designed to bring about

public support for capacity reduction or at least to reduce political opposition.

4. Sufficient funds must be made available to stimulate voluntary action to reduce capacity or to reduce the likelihood of successful constitutional challenges to government action. Funds required will vary with each situation and with the approach developed to reduce capacity. Such funds may be needed to satisfy current long-term debt; to purchase equity or fixed assets; to satisfy current liabilities; to satisfy employees' rights (especially unemployment compensation and accrued but unfunded benefits) and contractors' rights; and to cover contingent liabilities, expenses for the consummation of mergers, and the costs of developing alternate uses of facilities. Surviving hospital corporations after mergers or partial closures must also have some assurance of maintaining adequate working capital and cash flow for a transitional period after capacity is reduced. Such funds can be furnished through grants or loans through flexible application of reimbursement systems, and through special relief from ceilings or payment limitations.

5. In developing plans designed to identify the amount and location of excess capacity and the priorities for action, it is unwise to require the health systems agency or the state agency to provide institu-

tion-specific designation of corporate consolidations on closures. Unless there is very strong public, professional, and political support for capacity reduction, such designations are likely to be so politically volatile that they can destroy the agencies. Perhaps even more importantly, to the extent that an effective program requires voluntary action, opportunities must be provided for negotiation and tradeoff which would be lost by institution-specific designations. Plans developed by such agencies can clearly and effectively indicate the direction of the capacity reduction program without impeding voluntary action.

6. All major purchasers and third party financing agencies (private and public) have a large financial stake in the outcome of a capacity reduction program. Their participation in and financial support of the program in an equitable manner should be stimulated and encouraged. If financial sanctions are imposed (assuming it is desirable and could be done legally), care should be taken to ensure that they support the policy framework and the priority system and that they can be equitably applied. For example, a proposal to reduce only Medicare and Medicaid reimbursement as a sanction might discriminate against inner city hospitals with large volumes of indigent and elderly patients and actually force closure of the wrong hospitals.

Our analysis raises these and other issues in more depth. Obviously, we believe that excess hospital capacity currently exists and that a rational approach to capacity reduction can be cost-effective.

Thank you for the opportunity to present some of our ideas. Naturally, I would be pleased to answer any questions.

SRG/bjl
1/26/78

SUBSTITUTE FOR

HOUSE BILL No. 4491

A bill to amend the title and section 1 of Act No. 256 of the Public Acts of 1972, entitled

"An act to require certificates of need for new construction or conversion of, addition to or modernization of health facilities; to provide for the issuing of certificates of need; to establish a state health facilities commission; to provide fees and penalties; and to make appropriations,"

being section 331.451 of the Compiled Laws of 1970; and to add sections 3a, 5b and 5c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. The title and section 1 of Act No. 256 of the Public Acts of 1972, being section 331.451 of the Compiled Laws of 1970, are amended and sections 3a, 5b and 5c are added to read as follows:

TITLE

An act to require certificates of need for new construction, ~~or~~ conversion, ~~of, addition to or~~ modernization of, OR ADDITION TO health facilities; to

provide for the issuing of certificates of need; TO PROMOTE THE EFFICIENT AND ECONOMICAL DELIVERY OF MEDICAL CARE SERVICES; TO PROVIDE FOR THE CLOSURE OF HOSPITALS OR CONSOLIDATION OF HOSPITALS OR SERVICES; to establish a state health facilities commission; TO ESTABLISH A TASK FORCE; to provide fees and penalties; and to make appropriations.

Sec. 1. As used in this act:

(a) "Addition" means adding patient rooms to a health facility or the adding of ancillary service areas or other accommodations resulting in a single project cost including construction, engineering, and fixed equipment in excess of an amount which shall be determined by the director with the approval of the ~~state health facilities~~ commission.

(b) "Certificate of need" means a certificate attesting to need for new construction, or conversion of, addition to, or modernization of a health facility.

(c) "Commission" means the state health facilities commission established by this act.

(d) "Consumer" means ~~any~~ AN individual not connected, directly, with any person, organization, corporation, or institution associated with the provision of health care and services. A doctor; nurse; administrator or operator of a hospital, nursing home, or home for the aged; agent or employee of a health insurance provider; a pharmacist; or one who contracts to perform services for the foregoing is not a consumer.

(e) "Conversion" means converting an existing building not previously licensed as a health facility to such use or converting of an area of any other institution to health facility use.

(F) "COUNCIL" MEANS THE STATEWIDE HEALTH COORDINATING COUNCIL DESIGNATED PURSUANT TO SECTION 1524 OF TITLE 15 OF THE PUBLIC HEALTH SERVICES ACT, 42

U.S.C. 300m-3.

~~(f)~~(G) "Department" means the department of public health.

~~(g)~~(H) "Director" means the director ~~of the department~~ of public health.

~~(h)~~(I) "Health facility" means a hospital or ~~any~~ A part ~~thereof~~ OF A HOSPITAL licensed by the department ~~of public health~~ in accordance with Act No. 17 of the Public Acts of 1968, AS AMENDED, being sections 331.411 to 331.430 of the MICHIGAN Compiled Laws, ~~of 1948~~ or Act No. 263 of the Public Acts of 1913, as amended, being sections 331.401 to 331.406 of the MICHIGAN Compiled Laws ~~of 1948~~. A HEALTH FACILITY DOES NOT INCLUDE A VETERANS FACILITY OPERATED BY THE STATE OR FEDERAL GOVERNMENT.

9a

(J) "HEALTH SYSTEMS AGENCY" MEANS A HEALTH SYSTEMS AGENCY DESIGNATED PURSUANT TO SECTION 1512 OF TITLE 15 OF THE PUBLIC HEALTH SERVICES ACT, 42 U.S.C. 300l-1.

~~(i)~~(K) "Modernization of the physical plant" means a major upgrading, alteration, or change in function of ~~any~~ A part or area of a health facility resulting in a single project cost including construction, engineering, and fixed equipment in excess of an amount which shall be determined by the director with the approval of the ~~state health facilities~~ commission. Modernization shall not include normal maintenance and operational expenses.

~~(j)~~(L) "New construction" means construction of a health facility where a health facility did not exist or construction as a replacement for an existing health facility.

~~(k)~~(M) "Person" means an individual, copartnership, corporation, association, agency, organization, or unit of government, including ~~any~~ A receiver, trustee, or assignee thereof.

(N) "STATE AGENCY" MEANS THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY DESIGNATED PURSUANT TO SECTION 1521 OF TITLE 15 OF THE PUBLIC HEALTH SERVICES ACT, 42 U.S.C. 300m.

(o) "SUBAREA" MEANS THE HEALTH FACILITY SERVICE AREA DEFINED BY THE DEPARTMENT.

SEC. 3A. (1) THE GOVERNOR SHALL APPOINT A TASK FORCE CONSISTING OF REPRESENTATIVES OF STATE AGENCIES, THE HOSPITAL INDUSTRY, THIRD PARTY PAYORS, FINANCIAL INSTITUTIONS, THE LEGAL PROFESSION, LICENSED HEALTH CARE PROFESSIONALS, AND OTHER AFFECTED PARTIES TO ADDRESS THE LEGAL ISSUES AND FINANCIAL PROBLEMS, PARTICULARLY WITH RESPECT TO CAPITAL FINANCING AND FINANCIAL EQUITY, ASSOCIATED WITH A REDUCTION IN EXCESS HOSPITAL CAPACITY. THE APPOINTMENTS SHALL BE MADE WITH THE ADVICE AND CONSENT OF THE SENATE. THE TASK FORCE SHALL SUBMIT QUARTERLY REPORTS AND A FINAL REPORT NOT LATER THAN OCTOBER 1, 1978, TO THE GOVERNOR AND THE LEGISLATURE. THE REPORTS SHALL INDICATE THE MEANS BY WHICH ISSUES AND PROBLEMS MAY BEST BE ADDRESSED TO MEET THE FINANCIAL OBLIGATIONS RESULTING FROM A REDUCTION IN EXCESS HOSPITAL CAPACITY. MECHANISMS SHALL BE DESIGNED TO INSURE THAT TO THE EXTENT THAT FEDERAL FUNDS ARE NOT AVAILABLE, AN EQUITABLE DISTRIBUTION OF COSTS TO ALL THIRD PARTY PAYORS WILL OCCUR.

(2) THIS SECTION SHALL EXPIRE OCTOBER 1, 1978.

SEC. 5B. (1) WITHIN 45 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, THE DEPARTMENT, AFTER CONSULTATION WITH THE HEALTH SYSTEMS AGENCIES AND WITH THE APPROVAL OF THE STATE AGENCY, SHALL PREPARE AND SUBMIT TO THE COUNCIL:

(A) GUIDELINES FOR IDENTIFYING THE APPROPRIATE HOSPITAL CAPACITY AND EXCESS HOSPITAL BEDS IN EACH SUBAREA.

(B) CRITERIA TO BE USED TO REVIEW AND APPROVE THE PLAN DEVELOPED BY A HEALTH SYSTEMS AGENCY PURSUANT TO SUBSECTION (6). ONE OF THE CRITERIA SHALL BE THE POTENTIAL OF THE PLAN FOR ASSURING APPROPRIATE ACCESS TO AND QUALITY OF MEDICAL CARE SERVICES FOR RESIDENTS OF THE AREA SERVED AND FOR ACHIEVING ECONOMIC SAVINGS CONSISTENT WITH THIS OBJECTIVE.

(2) THE GUIDELINES AND CRITERIA SUBMITTED BY THE DEPARTMENT AND APPROVED PURSUANT TO SUBSECTION (4) AND THE PLANS DEVELOPED PURSUANT TO SUBSECTION (6)

SHALL CONSIDER THE FACTORS AND CRITERIA IN SECTION 5A AND THE FOLLOWING, WHERE APPROPRIATE:

(A) THE APPLICABLE HEALTH SYSTEMS PLAN AND ANNUAL IMPLEMENTATION PLAN ADOPTED PURSUANT TO 1513(b)(2) AND (3) OF TITLE 15 OF THE PUBLIC HEALTH SERVICES ACT, 42 U.S.C. 300l-2.

(B) THE LONG-RANGE DEVELOPMENT PLANS, IF ANY, OF FACILITIES PROVIDING ACUTE CARE SERVICES IN THE AREA.

(C) THE NEEDS OF THE POPULATION OF THE AREA FOR ACUTE CARE SERVICES.

(D) THE IMMEDIATE AND LONG-TERM IMPACT OF THE ACTIONS PROPOSED ON THE COSTS AND CHARGES FOR PROVIDING HEALTH SERVICES IN THE AREA.

(E) THE RELATIONSHIP OF THE SERVICES PROPOSED TO BE DISCONTINUED TO THE HEALTH CARE SYSTEM OF THE AREA.

(F) THE AVAILABILITY OF RESOURCES, INCLUDING HEALTH MANPOWER, MANAGEMENT PERSONNEL, AND FUNDS FOR CAPITAL AND OPERATING NEEDS, FOR THE PROVISION OF HOSPITAL SERVICES AND THE POTENTIAL FOR ALTERNATIVE USES OF THOSE RESOURCES FOR THE PROVISION OF OTHER HEALTH CARE SERVICES.

(G) THE RELATIONSHIP, INCLUDING THE ORGANIZATIONAL RELATIONSHIP, OF THE HEALTH SERVICES PROPOSED TO BE DISCONTINUED TO ANCILLARY OR SUPPORT SERVICES.

(H) SPECIAL NEEDS AND CIRCUMSTANCES OF THOSE ENTITIES WHICH PROVIDE A SUBSTANTIAL PORTION OF THEIR SERVICES OR RESOURCES OR BOTH, TO INDIVIDUALS NOT RESIDING IN THE AREA IN WHICH THE ENTITIES ARE LOCATED OR IN ADJACENT AREAS. THE ENTITIES MAY INCLUDE MEDICAL AND OTHER HEALTH PROFESSIONS SCHOOLS, MULTIDISCIPLINARY CLINICS, AND SPECIALTY CENTERS.

(I) THE SPECIAL NEEDS AND CIRCUMSTANCES OF HEALTH MAINTENANCE ORGANIZATIONS FOR WHICH ASSISTANCE MAY BE PROVIDED UNDER TITLE 18 OF PUBLIC LAW 93-222, 42 U.S.C. 300e TO 300e-15. THE NEEDS AND CIRCUMSTANCES INCLUDE THE NEEDS OF, AND COSTS TO, MEMBERS AND PROJECTED MEMBERS OF THE HEALTH MAINTENANCE

ORGANIZATION IN OBTAINING HEALTH SERVICES AND THE POTENTIAL FOR A REDUCTION IN THE USE OF INPATIENT CARE IN THE COMMUNITY THROUGH AN EXTENSION OF PREVENTIVE HEALTH SERVICES AND THE PROVISION OF MORE SYSTEMATIC AND COMPREHENSIVE HEALTH SERVICES.

(J) THE SPECIAL NEEDS AND CIRCUMSTANCES OF BIOMEDICAL AND BEHAVIORAL RESEARCH PROJECTS WHICH ARE DESIGNED TO MEET A STATE NEED AND FOR WHICH LOCAL CONDITIONS OFFER SPECIAL ADVANTAGES.

(K) THE NEED AND AVAILABILITY IN A COMMUNITY FOR SERVICES AND FACILITIES FOR OSTEOPATHIC AND ALLOPATHIC PHYSICIANS, OTHER LICENSED HEALTH CARE PROFESSIONALS, AND THEIR PATIENTS.

(L) THE IMPACT ON EXISTING AND PROPOSED INSTITUTIONAL TRAINING PROGRAMS FOR DOCTORS OF ALLOPATHIC AND OSTEOPATHIC MEDICINE AND OTHER LICENSED HEALTH CARE PROFESSIONALS AT THE STUDENT, INTERNSHIP, AND RESIDENCY TRAINING LEVEL.

(M) THE DEGREE TO WHICH PHYSICIANS AND SURGEONS WHO ARE AFFECTED BY THE CLOSURE OR CONSOLIDATION OF HEALTH FACILITIES OR PROFESSIONAL SERVICES HAVE ACCESS TO THE PHYSICIAN STAFFS OF OTHER HEALTH FACILITIES IN THE AREA AFFECTED.

(3) SUBSECTION (2) SHALL NOT BE CONSTRUED TO DICTATE A DEPARTURE FROM GOOD HEALTH PLANNING PRINCIPLES OR TO MANDATE UNNECESSARY DUPLICATION OF SERVICES OR FACILITIES.

(4) THE COUNCIL MAY APPROVE THE GUIDELINES AND CRITERIA WITHIN 90 DAYS AFTER IT RECEIVES THE GUIDELINES AND CRITERIA PURSUANT TO SUBSECTION (1). THE COUNCIL MAY MODIFY THE GUIDELINES AND CRITERIA BEFORE IT APPROVES THEM. IF THE COUNCIL DOES NOT APPROVE THE GUIDELINES AND CRITERIA WITHIN 90 DAYS AFTER THE COUNCIL RECEIVES THEM, THE GUIDELINES AND CRITERIA SHALL BE CONSIDERED APPROVED AS SUBMITTED BY THE DEPARTMENT. THE GUIDELINES AND CRITERIA SHALL BE INCLUDED IN THE STATE HEALTH PLAN DEVELOPED PURSUANT TO SECTION 1524 OF TITLE 15 OF THE PUBLIC HEALTH SERVICES ACT, 42 U.S.C. 300m-3.

(5) WITHIN 30 DAYS AFTER THE FIRST GUIDELINES AND CRITERIA ARE APPROVED PURSUANT TO SUBSECTION (4) AND ANNUALLY THEREAFTER, THE DEPARTMENT SHALL PREPARE, IN ACCORDANCE WITH THOSE GUIDELINES AND CRITERIA, AND PUBLISH A LIST WHICH IDENTIFIES EACH SUBAREA HAVING EXCESS HOSPITAL BEDS. A SUBAREA THAT HAS LESS THAN 25 EXCESS BEDS SHALL NOT BE INCLUDED IN THE LIST. THE LIST SHALL SPECIFY THE APPROPRIATE HOSPITAL CAPACITY AND THE NUMBER OF EXCESS HOSPITAL BEDS IN EACH SUBAREA.

(6) WITHIN 210 DAYS AFTER THE FIRST LIST DEVELOPED PURSUANT TO SUBSECTION (5) IS PUBLISHED, AND ANNUALLY THEREAFTER, A HEALTH SYSTEMS AGENCY THAT SERVES A SUBAREA WHICH IS ON THE LIST MAY PREPARE A PLAN FOR THE REDUCTION OF EXCESS HOSPITAL CAPACITY IN ACCORDANCE WITH THIS SUBSECTION, SUBSECTION (7), AND THE GUIDELINES AND CRITERIA APPROVED PURSUANT TO SUBSECTION (4). THE PLAN SHALL SPECIFY HOW EACH HOSPITAL IN THE SUBAREA IS AFFECTED AND SHALL PRESCRIBE AN ANNUAL SCHEDULE FOR IMPLEMENTATION. THE PLAN SHALL BE SUBMITTED

TO THE COUNCIL. THE HEALTH SYSTEMS AGENCY MAY DEVELOP AND APPLY DIFFERENT CRITERIA AND GUIDELINES TO A SUBAREA IF THE HEALTH SYSTEMS AGENCY BELIEVES THAT THE SUBAREA HAS UNUSUAL CIRCUMSTANCES WHICH CANNOT BE READILY RESOLVED IN ACCORDANCE WITH THE APPROVED GUIDELINES AND CRITERIA. THE PROCESS UNDER WHICH THE PLAN IS DEVELOPED BY THE HEALTH SYSTEMS AGENCY SHALL BE CONSISTENT WITH THE PREPARATION AND ESTABLISHMENT PROCEDURES REQUIRED BY FEDERAL REGULATION FOR THE DEVELOPMENT OF HEALTH SYSTEMS PLANS UNDER THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974, 42 U.S.C. 300k TO 300t. THE PLAN SHALL PROVIDE FOR THE ADJUSTMENT OF THE HOSPITAL CAPACITY TO THE APPROPRIATE LEVEL WITHIN 5 YEARS AFTER THE PLAN IS APPROVED BY THE COUNCIL OR DEVELOPED BY THE DEPARTMENT.

(7) IN DEVELOPING A PLAN TO REDUCE EXCESS HOSPITAL BEDS, THE HEALTH SYSTEMS AGENCY OR THE COUNCIL SHALL FIRST CONSIDER THE POSSIBILITY OF CONSOLIDATION OF 2 OR MORE HOPSITALS IN THE SUBAREA. IF CONSOLIDATION IS INAPPROPRIATE OR INSUFFICIENT FOR THE PLAN, THE CLOSURE OF HOSPITALS SHALL NEXT BE CONSIDERED. THE CLOSURE OF HOSPITALS SHALL ONLY BE CONSIDERED AFTER ALL REASONABLE EFFORTS HAVE BEEN MADE TO ENCOURAGE AND, IF NECESSARY, ASSIST IN THE CONSOLIDATION OF 2 OR MORE HOSPITALS. A STATEMENT INDICATING WHAT ACTIONS WERE TAKEN TO ENCOURAGE OR ASSIST CONSOLIDATION AND THE REASONS WHY THIS PRIORITY WAS NOT SELECTED SHALL BE INCLUDED IN THE PLAN. IF CLOSURE OF A HOSPITAL IS INAPPROPRIATE OR INSUFFICIENT FOR THE PLAN, THE CONSOLIDATION OF MAJOR CLINICAL SERVICES AMONG 2 OR MORE HOSPITALS SHALL NEXT BE CONSIDERED. IF THE CONSOLIDATION OF MAJOR CLINICAL SERVICES IS INAPPROPRIATE OR INSUFFICIENT, THE CLOSURE OF NURSING UNITS WITHIN A HOSPITAL SHALL NEXT BE CONSIDERED. THE COUNCIL SHALL NOT APPROVE A PLAN WHICH DOES NOT ADDRESS THE PRIORITIES DESCRIBED IN THIS SUBSECTION.

(8) IF A HEALTH SYSTEMS AGENCY DOES NOT SUBMIT A PLAN WITHIN 210 DAYS AFTER THE LIST IS PUBLISHED PURSUANT TO SUBSECTION (5), THE COUNCIL MAY DEVELOP A PLAN FOR THAT SUBAREA. IF THE PLAN PREPARED BY THE HEALTH SYSTEMS AGENCY IS NOT CONSISTENT WITH THE GUIDELINES AND CRITERIA APPROVED PURSUANT TO SUBSECTION (4) OR THE LIST PUBLISHED PURSUANT TO SUBSECTION (5), THE HEALTH SYSTEMS AGENCY SHALL PROVIDE SATISFACTORY DOCUMENTATION TO JUSTIFY THE DIFFERENCES.

WITHIN 120 DAYS AFTER THE PLAN IS SUBMITTED TO THE COUNCIL, THE COUNCIL MAY DO ANY OF THE FOLLOWING:

(A) APPROVE THE PLAN AS SUBMITTED.

(B) AMEND THE PLAN TO CONFORM WITH THE CRITERIA AND GUIDELINES APPROVED PURSUANT TO SUBSECTION (4) AND THE LIST PUBLISHED PURSUANT TO SUBSECTION (5) AND APPROVE THE PLAN AS AMENDED.

(C) DISAPPROVE THE PLAN AND DEVELOP A SUBSTITUTE PLAN WHICH CONFORMS WITH THE CRITERIA AND GUIDELINES APPROVED PURSUANT TO SUBSECTION (4) AND THE LIST PUBLISHED PURSUANT TO SUBSECTION (5).

(D) PERMIT A HEALTH SYSTEMS AGENCY TO REVISE ITS PLAN AND APPROVE THE PLAN AS REVISED.

(9) IF A PLAN IS NOT APPROVED BY THE COUNCIL WITHIN 120 DAYS AFTER THE PLAN IS SUBMITTED TO THE COUNCIL OR 330 DAYS AFTER THE LIST IS PUBLISHED PURSUANT TO SUBSECTION (5), THE DEPARTMENT SHALL DEVELOP A PLAN WITHIN 90 DAYS.

SEC. 5C. (1) AFTER THE DEPARTMENT PUBLISHES A LIST PURSUANT TO SECTION 5B(5), THE DEPARTMENT SHALL NOT ISSUE A CERTIFICATE OF NEED TO A HEALTH FACILITY LOCATED IN A SUBAREA IDENTIFIED AS HAVING EXCESS HOSPITAL BEDS UNTIL A PLAN FOR THE ELIMINATION OF THOSE BEDS IS APPROVED BY THE COUNCIL OR THE DEPARTMENT OR UNTIL 14 MONTHS AFTER THE DATE OF PUBLICATION OF THE FIRST LIST PURSUANT TO SECTION 5B(5), WHICHEVER IS SOONER. THIS SUBSECTION SHALL NOT APPLY TO A PROJECT EXEMPT UNDER SUBSECTIONS (2) AND (3) OR SUBSECTION (4) OR (5).

(2) A PROJECT DESCRIBED IN THE CERTIFICATE OF NEED APPLICATION SHALL BE EXEMPT FROM SUBSECTION (1) IF, IN ADDITION TO THE CONDITIONS PRESCRIBED BY SUBSECTION (3), THE DEPARTMENT, IN CONSULTATION WITH THE APPROPRIATE HEALTH SYSTEMS AGENCY, DETERMINES THE PROJECT IS ONE FOR WHICH BOTH OF THE FOLLOWING APPLY:

(A) THE PROJECT DOES NOT INCLUDE AN ADDITION TO THE BED SUPPLY.

(B) THE PROJECT WOULD NOT RESULT IN A SIGNIFICANT INCREASE IN THE HEALTH FACILITY'S SERVICE PROGRAM, A MAJOR NEW SERVICE, OR NEW TECHNOLOGY.

(3) A PROJECT DESCRIBED IN THE CERTIFICATE OF NEED APPLICATION SHALL BE EXEMPT FROM SUBSECTION (1) IF, IN ADDITION TO THE REQUIREMENTS PRESCRIBED BY SUBSECTION (2), THE PROJECT MEETS 1 OF THE FOLLOWING CONDITIONS:

(A) THE PROJECT IS REQUIRED TO CORRECT AN EMERGENCY SITUATION WHICH IF NOT CORRECTED IMMEDIATELY WOULD THREATEN THE SAFETY AND WELFARE OF THE PATIENTS AND STAFF; OR IS REQUIRED BY FEDERAL LAW AS A CONDITION OF PARTICIPATION IN TITLE 18 OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1395 TO 1395pp, OR TITLE 19 OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396 TO 1396j.

(B) THE PROJECT CONSTITUTES A NONSUBSTANTIVE PROJECT MEETING AN ALREADY DEMONSTRATED COMMUNITY NEED ACCEPTABLE TO THE DEPARTMENT AND APPROPRIATE HEALTH SYSTEMS AGENCY.

(C) THE PROJECT CONSTITUTES A CHANGE IN OWNERSHIP NOT RESULTING IN A CAPITAL EXPENDITURE WHICH IS THE RESULT OF A MERGER, CORPORATE CONSOLIDATION, OR CLINICAL SERVICE CONSOLIDATION AMONG 2 OR MORE HOSPITALS.

(4) A PROJECT DESCRIBED IN THE CERTIFICATE OF NEED APPLICATION SHALL BE EXEMPT FROM SUBSECTION (1) IF THE DEPARTMENT, IN CONSULTATION WITH THE APPROPRIATE HEALTH SYSTEMS AGENCY, DETERMINES THE PROJECT IS A SUBSTANTIVE PROJECT INTENDED TO IMPLEMENT THE RESULTS OF A MERGER, CORPORATE CONSOLIDATION, OR CLINICAL SERVICE CONSOLIDATION AMONG 2 OR MORE HOSPITALS AND WILL RESULT IN A SIGNIFICANT REDUCTION IN BED OR SERVICE CAPACITY.

(5) A PROJECT DESCRIBED IN THE CERTIFICATE OF NEED APPLICATION SHALL BE EXEMPT FROM SUBSECTION (1) IF THE APPLICATION HAS BEEN ACCEPTED BY THE DEPARTMENT FOR FILING AS OF THE EFFECTIVE DATE OF THIS SECTION.

(6) HOSPITAL BEDS AND SERVICES FOR WHICH A CERTIFICATE OF NEED IS GRANTED

AFTER THE EFFECTIVE DATE OF THIS SECTION, BUT BEFORE THE APPROVAL OF A BED REDUCTION PLAN DEVELOPED PURSUANT TO SECTION 5B, SHALL NOT BE EXEMPT FROM SUBSEQUENT IDENTIFICATION FOR ELIMINATION IN A PLAN FOR THE REDUCTION OF HOSPITAL BEDS AS PROVIDED FOR IN SECTION 5B.

(7) THE DEPARTMENT SHALL NOT ISSUE A CERTIFICATE OF NEED THAT IS INCONSISTENT WITH A HOSPITAL BED REDUCTION PLAN APPROVED OR DEVELOPED PURSUANT TO SECTION 5B. THE DEPARTMENT SHALL NOT ISSUE A CERTIFICATE OF NEED TO A HOSPITAL WHICH IS NOT IN CONFORMANCE WITH A PLAN AS PROVIDED FOR IN SECTION 5B.

Mr. ROGERS. Thank you very much, Mr. Gottlieb, for some helpful suggestions.

Mr. Thomas E. Greene.

STATEMENT OF THOMAS E. GREENE III

Mr. GREENE. Chairman Rogers and members of the subcommittee, my name is Tom Greene, and I am the vice president of Lehman Bros., Kuhn, Loeb, Inc., and we are investment bankers in New York City. However, my statement this morning is presented on behalf of the Hospital Financing Study Group, which is an association of the public finance departments of most of the investment banking firms in the country who do health care capital financing.

With me is Mr. Tom Quinn, who is General Counsel of our group.

In order to help the subcommittee keep its schedule, I will try to keep my comments as brief as possible.

Last May, our chairman, David Fearheller of John Nuveen & Co., appeared before the subcommittee during your consideration of the administration's cost containment bill. In addition to outlining our fears about the effect which that legislation might have on the financial markets and on the health care delivery system itself, Mr. Fearheller had this to say: "We of the Hospital Financing Study Group have made a commitment to support rigorous local planning in order to assure that only those construction projects which meet a clear community need will receive financing."

That commitment, which remains strong, is the reason for my being here today, to share with you the views of the health care financing community on the health planning and resources development amendments of 1978.

We are pleased to see, in H.R. 10460, amendments to the planning law which will help to fulfill the promise of competent and successful local planning, embodied in Public Law 93–641. Only through the efforts of these planners, familiar with the needs and resources available in their own areas, and generally free of political motives, can we gain confidence that our scarce health resources will be applied most efficiently and most wisely. Thus, we are in wholehearted support of this bill's addition of two new national health priorities: first, the retirement of unnecessary health care facilities and, second, the containment of health care costs. As investment bankers to the hospital industry, members of our group have important roles to play in helping to achieve both of these goals. Mr. Chairman, we take that responsibility very seriously and therefore expect to continue our close cooperation with the local planning agency.

A principal ingredient added by H.R. 10460 to achieve the goal of retiring unneeded hospital capacity is section 219(b). That section would require each State to create a program for converting appropriateness review to decertification within 4 years. In effect, an institutional service, or, for that matter, an entire institutional provider of health services, will be required, under these State programs, to discontinue operations if the services are found to be inappropriate. Assuming that the appropriateness review itself is professionally managed, and its conclusion fully justified, one can hardly argue with the logic and effectiveness of such an enforcement approach.

You may recall, however, that the Hospital Financing Study Group was vigorously opposed to similar decertification authority contained in earlier versions of what became Public Law 93–641. Our opposition, then as now, was founded upon our appreciation of the effects that such a provision would have upon the security of long-term debt, particularly tax-exempt hospital bonds, which are used to provide the majority of capital for the hospital industry. Obviously, a bond that matures in 30 years is not a particularly attractive investment, when the hospital which provides the stream of revenue securing the bond can be closed by quasi-governmental action at any time prior to maturity. When such a provision was suggested in 1974, the bond-rating agencies in New York took the position that its inclusion in the legislation would force them to stop rating hospital bonds entirely. In short, enactment of section 219(b) in its present form would devastate the market for hospital bonds, with the attendant costs inevitably showing up as yet further fuel for the health care inflation which exists today.

Fortunately there is a compromise between the good sense of providing a means for retiring unnecessary facilities and the need for maintaining a viable capital-raising mechanism which is both practical and cost-effective. The compromise is, of course, to provide for retirement of the debt associated with facilities that are decertified. That approach has been suggested in various forms: In title III of this subcommittee's H.R. 9717, Senator Talmadge's S. 1470, and in the Senate version of the planning act amendments, S. 2410. The common element among these legislative proposals for dealing with excess capacity is an appreciation that money spent to make facility retirement a practical option, will be repaid many times in operating costs savings. The Hospital Financing Study Group urges this subcommittee to complete the work that the present section 219(b) only begins. That is, couple the authority to decertify health facilities with the responsibility to provide for the debt, equity, and other closeout costs associated with the discontinued services.

In drafting the necessary additions to facilities retirement provisions of this bill, I would offer only one overriding suggestion: strive to make the provision as fair and equitable to all parties as is possible. If the provisions for retirement payment do not compensate for all of the economic disincentives for closure, elimination of excess capacity will meet strong resistance from all of the parties involved. It will be tempting to save dollars now by skimping on the funds to be made available for facility retirement, but the incremental costs of a fully equitable payment system will be more than offset by the cooperation which these additional funds will buy. In any case, a fair system for absorbing the cost of retiring unnecessary facilities could be the best investment of scarce funds which the Government can make because of the available savings in operating expenses.

One final note about funding these retirement payments seems in order. Obviously, because of medicare and medicaid, the Federal Government has a financial stake which justifies expenditures aimed at retiring excess capacity and creating a more efficient health care delivery system, but the savings from a workable decertification program will be shared by other third-party payers as well. We have all heard a great deal recently from Blue Cross and other health insur-

ance companies about their efforts to deal with excess capacity. It seems in order to inquire of these other payors whether they would participate in these retirement payments to the same extent that they are likely to participate in the savings. Simply asking the question may go a long way toward dividing rhetoric from action.

In terms of our own action, I offer this subcommittee the expertise of the hospital financing community in the process of drafting and implementing a practical and affordable system for achieving the objectives of cost containment and decertification of truly excess hospital capacity.

Mr. Chairman, that concludes my statement, but Mr. Quinn and I would be happy to answer any of your questions.

Mr. ROGERS. Thank you, Mr. Greene.

Mr. Florio?

Mr. FLORIO. I would like to ask Dr. Gottlieb a question.

In this fairly extensive study that you and your organization became involved with, was there any discussion or exploration of the whole question of physician privileges at hospitals; and the feeling that unlimited privileges at a hospital may very well assist in expediting the closing of unneeded facilities? Some feel the whole concept of privileges at a hospital is conducive to each hospital's attempting to develop its facilities to the fullest extent because of the need of a physician to feel that his hospital should be a total care unit. If we are going to start to practice a higher degree of coordination then unlimited privileges would be a facilitating factor in having hospitals cooperate more.

Mr. GOTTLIEB. Yes. We addressed that somewhat, and we recognize that that, in fact, is a part of the problem. But we also recognize that the medical staff privilege system, with all of its flaws, is one of the best quality control mechanisms that we have in the whole hospital field and part of the question is, how do you bring the two kinds of concerns together.

Marginal hospitals that have been developed and maintained in large cities of the type we are talking about closing, came about partly in order to serve marginal physicians.

Mr. FLORIO. Marginal physicians?

Mr. GOTTLIEB. Marginal physicians. And the question is how can we get the professional community to address the problem of bringing on to the medical staff, with some reasonable degree of quality control, those physicians who would be displaced if you reduced capacity.

Mr. FLORIO. When you say "marginal physicians," are you talking about economically marginal physicians or quality marginal——

Mr. GOTTLIEB. Quality marginal physicians.

Mr. FLORIO. Do you think that is really the role of a hospital, to be determining the qualifications of a physician? Are there not appropriate State boards for that sort of thing?

Mr. GOTTLIEB. That has been part of the role that the hospitals have been asked to assume since 1918.

Mr. FLORIO. By whom?

Mr. GOTTLIEB. When the first standards for hospitals were set by the American College of Surgeons.

Mr. FLORIO. You are talking about an internal decision of the hospital?

Mr. GOTTLIEB. A decision, really, of the whole system sometimes.

Mr. FLORIO. In a sense what we are questioning now, I suppose, is the system, and——

Mr. GOTTLIEB. Yes, we are questioning that, and how to, in a reasonable way, recognizing the practical difficulties, of changing the system without destroying its good aspects.

Mr. FLORIO. To the gentleman with regard to the Michigan legislation, you mentioned the necessity because of the constraints of time, the need to review vacancy levels, and the whole question of excess beds.

Did that deal with beds in terms of the total hospital operation, or did it get to specialty beds as well? I am thinking of obstetrics, for example, the fact that whether a hospital should have any beds in this area. This is something that is being talked about around the country, and I was just wondering if your legislation addresses the need to review, not the totality of the hospital bed facilities, but also the specialized beds.

Mr. SHELTON. Yes, it would. The bed-need methodology that would be used in the criteria that would be approved by the SHCC would address that issue.

Mr. FLORIO. How long has this piece of legislation been in operation?

Mr. SHELTON. We have been working on it for a little over a year now.

Mr. FLORIO. In other words, the bill has not passed yet?

Mr. SHELTON. The bill is out of the House Appropriations Committee and out of the House Public Health Committee. It was supposed to have been voted on the Floor last Thursday but, because of a blizzard, it was not.

Mr. FLORIO. To Mr. Greene, your comments sound very much like the policy statement that the American Hospital Association puts forth wth regard to its voluntary plan to counteract the initiatives in the cost-containment bill. What I am making reference to are the last two or three paragraphs in the statement that I saw, which talks about the need to exert political pressure on the Congress to enact legislation that would provide for tax credits and other appropriate legislation to subsidize the costs of some of the practices that hopefully would reduce excess bed capacity and contribute to an overall cost-containment policy by the hospitals voluntarily, without the need for legislation.

You said today that you thought that it was appropriate that the Congress—I assume you were referring to the Congress—enact legislation that is designed to provide for reimbursement to the bondholders for the elimination of bed capacity that was secured, or rather that the bonds secured when the bonds were constructed.

Do you feel that the bondholders or the bond market, should be required to contribute a portion of the costs rather than exclusively going to the public sector for reimbursement? It seems to me that somebody made some bad decisions in financing excess capacity, and if we are talking about the private market and the risk taking. then maybe it might not be appropriate to shift the entire cost over to the public sector.

Mr. GREENE. Congressman, I think as a practical matter, you have to look at this prospectively. If you look at the debt market as a spectrum, section 219(b) in its present form will force those hospitals which are at the top of the spectrum to pay much higher interest rates at the time that they issue new debt. And most of those hospitals in the spectrum would be excluded altogether from future capital financing. I think that is really the basis of what we are talking about, that is, the prospective effect of what you might be proposing here.

Mr. FLORIO. Well, in terms of quality control, now we have talked in terms of physicians quality control, let's talk about the bond markets' quality control.

Is that not going to result in some quality control evaluation in terms of the market and what it is going to finance in the future? The market is going to become much more involved in seeing whether something is going to be questioned at a later point, as excess capacity, and as in the past, a too easy flow of funding that was not as scrutinized as perhaps it could have been. Therefore we may very well be building into the system the responsibility on the part of the bond market to see that it is going to be financing things that are beyond challenge at a later point.

Is that not a secondary consideration that may be of some value, not only to the market, but to our society as a whole?

Mr. GREENE. Congressman. I think you must understand that the lending institutions and the investing public are not required to participate in the hospital financing process. If they perceived that the risks associated with investing their money are being substantially increased—by the added threat of decertification—then they may well just throw up their hands and forego participating in the hospital financing process altogether.

Mr. FLORIO. Well, is that not the impact on the entire market? They are not required to take part in any aspect of our market. In fact, the evaluation of the risk is something that I assume goes on in a continuing way.

All I am suggesting is that apparently in the past, the evaluation process has not been as diligent as it perhaps should be and if we want that process to be more diligent. From the standpoint of the market as well as from the standpoint of the society what we are suggesting would be beneficial.

Mr. QUINN. May I say something about that, Congressman? You are right. Investors already take into consideration these possible contingencies in the bond market. Adding the threat of decertification without full compensation would just be a question of paying for an additional risk: Either not being eligible for market bonds at all, or having to pay 14 or 15 percent, or whatever the interest rate would be. The point is, adding that risk would just escalate our costs one more notch.

We all agree that some sort of curtailment of hospital construction is in order, but we also agree that there has to be some construction in the future. Everyone agrees, even the Secretary of HEW, that there has to be some construction. That has to be financed somehow. If it is not financed in the bond market, it is going to be financed directly by government subsidy or government grant. So there has to be some way to get some money in the hospital construction area.

Mr. FLORIO. I will conclude on that point, but all I am suggesting to you is if the construction which is desirable from this point forward is desirable from all standpoints—that is, medically and financially—it seems to me that the market is going to be able to obtain a reasonable rate of return on the moneys that are involved. They are going to now be much more diligent in evaluating the desirability of that construction which is needed. I am just pointing out that, in the past, I do not think that degree of diligence has been there, or else we would not be here talking about excess capacity.

Mr. GREENAWALT. May I respond to that, sir?

I think something that has been missed in your questioning is that many of the hospitals in the country, and Michigan in partcular, were built or were expanded during a period of time when bed methodology said we were underbedded. As recently as 1970 in Michigan there was a finding that Michigan had too few beds and that a 5-year plan was needed to build more beds.

What has happened in Michigan is that there has been a severe reduction in length of stay and the statistics that Mr. Shelton gave earlier, that we have gone from an 82-percent occupancy rate to a 75-percent occupancy rate is not the result of more beds being built, it is a result of fewer patient days, it is a result of technological change and a lot of other things that have happened in utilization review.

I do not think it is that kind of risk that a bondholder looks at. There is no way to anticipate that length of stay may drop another day in the next 4 or 5 years, or considerably more than that, and that is not the risk that the bondholder takes, nor was it an expectation.

Mr. FLORIO. I suppose really what I am saying is that it is not much more different than a bondholder going in and financing a manufacturing plant in the Northeast where we no longer have the market for the particular product. I just do not see the difference except, in the area which we are talking about now, we are going to insure—in fact, some suggestions were adopted—that there be some subsidy there to buy out the closing of the excess capacity.

I am not sure that there is that much difference between traditional, private sector operations and what we are talking about in terms of capital construction in the hospital.

Mr. QUINN. Even direct subsidy is not an unprecedented government policy if we consider the railroads or the steel mills. When the Government switched its policy to the automobiles from the railroads and the railroads were in serious trouble, the Government was forced to provide subsidies to keep them running.

In the steel mills—we have a new trade policy. The steel mills are antiquated, new capital has not been put in, and we have certain policies to offset some of our trade problems.

Mr. FLORIO. I am not sure you really want to use the analogy of the railroads to the Congress. as much as from——

Mr. QUINN. Use the analogy in this sense: If there had been proper maintenance and construction of railroads over the last 40 years, they would not be in the shape they are in now.

If we stop renovating, modernizing, and maintaining our hospitals, a very few years down the road we are going to be in the very same situation the railroads are in, having old, rundown, antiquated hospitals.

Mr. FLORIO. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Waxman?

Mr. WAXMAN. I do not know particularly who to direct this question to, so whichever of you wishes to respond. Last fall, the Institute of Medicine published a report entitled "Controlling the Supply of Hospital Beds." It cited powerful community influences to build new hospitals, expand old ones, and resist the closing of unneeded ones, regardless of their efficiency or financial viability.

Among these influences were community pride, influential sponsors of hospital expansion, and the economic attraction of a large hospital payroll in the community. Robert Claiborne in the New York Times recently pointed out additional influences: Local bankers like to make construction loans, contractors and construction workers want the work.

There really are not any incentives not to expand hospitals.

Do we know that the health systems agencies and State planning agencies are any less vulnerable to these influences?

Mr. SHELTON. Maybe I could take the first crack at the answer.

The legislation that we are attempting to pass in Michigan, I think will deal specifically with that problem because it requires that a plan be developed based on criterion guidelines approved by the statewide health coordinating council which will identify institution-specific hospitals. They will be identified by the health systems agency to be phased out over a 5-year period, either through mergers, consolidation and mergers, or closure.

So the Michigan legislation would; I think, deal with that problem, that question.

Mr. WAXMAN. Mr. Gottlieb?

Mr. GOTTLIEB. I will try to get at it. Assuming that that were all true that you read—and I do not agree with a lot of it—the fact is no, that the health systems agencies and the State agencies are not any more immune to those influences. Part of the problem is that you are dealing with a political process, with a substructure of support for these facilities, an economic base, a contribution to the economic base of the community that is very real.

People have a strong interest for a variety of reasons and they are going to use, as they always do, whatever means they can to try to get their interest served.

It is very difficult to stop new things from happening, even through this process, because it is, after all, partly a political process. You have a technical structure defining what you think you need, and then you apply it to the political process and you see how it comes out.

When you start talking about closing existing facilities or reducing existing capacity, it gets that much tougher, because you are taking something away from people that they already have. You cannot talk about full employment on the one hand and laying off 11,000 people on the other and not have a serious problem which you are going to have to deal with through the political and economic process.

So that no, they are not immune. You have just added a much more difficult layer if you add to their role the authority to close existing facilities.

Mr. WAXMAN. Mr. Gottlieb, GAO did a study and found the approval rate for new construction, or expansion of existing facilities

was 92 percent, even with our health planning agencies in place. Don't you think this is too high a rate and, if we give them the power to close existing facilities, do you think that they would be any more vigorous?

Mr. GOTTLIEB. I do not know whether that is too high a rate. I think that all of us would have to look at what was considered, what the programs were, how they related to what the community needs and how it fit into the community decisionmaking process and the political process of the State and then maybe we could decide whether it was too high or too low. It might even be too low.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. ROGERS. Of course, I am not sure we have too much to judge, yet. We have the HSA's which have just been in existence some a year, some less. Only nine have really been certified yet.

So perhaps we are prejudging what has happened, or what may happen. But generally, I think the feeling is they have been constructive, and hopefully they can do a good job.

I think, first of all, the committee wants to express its thanks to each of you for coming here on such short notice and preparing your testimony to help us and I think your experience in Michigan will be most helpful to us, and the bill that has been presented for enactment by your legislature will certainly be examined by this committee.

We do have, in the cost containment legislation, provisions for helping to retire debt for facilities that are closed.

Would you say that would almost amount to a guaranteed loan?

It would almost have the same effect?

So that, should there be a reduced interest rate to the hospitals in this sector when the Government is almost guaranteeing that the payoff will be assured and that you will not have any substantial loss on your money——

Mr. GREENE. Well, certainly, Mr. Chairman, to the extent that there is a reduction in the perceived risk of the investment, the interest rate will be lower.

Mr. ROGERS. So we may anticipate a lower interest rate to the public, in effect, if we were to enact such a program.

Mr. QUINN. But it does not guarantee the loan. It guarantees that the Government, or some other agency, steps in and says, this facility should no longer be in existence, that the debt and equity associated with the facility will be provided for. But it does not guarantee that bankruptcy cannot happen, nor would it protect against any other thing in the current marketplace. That risk stays present. It just takes away——

Mr. ROGERS. Well, not too much, if it is an excess facility. I presume you would not have bankruptcy, as long as it is declared excess and you pay off the debt for it.

Mr. QUINN. Well, so long as there is the tight squeeze on Medicaid in many of the States, in that the payment rates are less than what cost is, that risk of bankruptcy stays real.

Mr. ROGERS. Well, that has always been so, has it not?

Mr. QUINN. I am just saying——

Mr. ROGERS. I mean, we are not changing that situation.

Mr. QUINN. No, we are not. That is what I am saying. The loan does not become guaranteed; there are still other factors——

Mr. ROGERS. Well, the payment of the debt becomes almost guaranteed.

Mr. QUINN. Only if an external agency steps in and says it is not needed.

Mr. ROGERS. It is not needed, or it is excess, and so forth.

Mr. QUINN. But if the market says it is not needed, or whatever other thing happens, that part is not taken care of.

Mr. ROGERS. Well, now, what do you do now if, say, you had a hospital and it only has 30 percent or 40 percent occupancy?

Mr. GREENE. In the normal situation where there is not decertification?

Mr. ROGERS. Yes, and the hospital is just not making it.

Mr. GREENE. I would say that any investors in that hospital would be in trouble, Mr. Chairman.

Mr. ROGERS. Well, there is no payment of the debt there, is there?

Mr. GREENE. No.

Mr. ROGERS. It just goes out of existence.

So I presume this is some guarantee, for the most part, for hospitals where an agency has the responsibility to determine excess capacity, which we have not done before. Normally, I would think, if you had a proper capacity and the hospital is operating properly, then this is almost a guaranteed loan for debt.

I just wanted to see what the reaction would be.

I think, to accomplish, as you say, support, you almost have to have some mechanism to help pay debt and to help build public support so that the community does not have to support that excess payment.

Mr. FLORIO. Mr. Chairman?

Mr. ROGERS. Yes.

Mr. FLORIO. If I may, just on that one point, does the market or the bond council or the bondholders' representatives feel any need or obligation to intervene in terms of internal operations of hospitals?

I assume that the money was put forth as a result of a prospectus that was drafted, and the expectation was that the hospitals needs would be forthcoming as a result of periodic rate increases or increases in Medicare payments and Medicaid payments. If, those increases have not been forthcoming to handle operating expenditures and capital expenditures as well, in many instances they have not been forthcoming because the agencies that are in charge of the approvals have felt that, internally, the hospitals have not done what they should do to minimize costs.

The hospitals say that they have these costs that are going up; the review agency is saying that you can cut those costs, and therefore we are not going to increase in amount.

Does the bondholders, the fiduciaries or whoever, feel the need when rate increases are not approved to suggest to the hospital that they undertake some cost-cutting mechanisms or procedures?

Mr. GREENE. We certainly do feel a very strong fiduciary responsibility to do whatever types of informal action we possibly can to see that the hospital is able to meet its obligations. I think our legal remedies are fairly restricted, but we certainly do, from time to time, when the occasion warrants, go to the hospital, make specific recommendations, and talk to the board of directors in our capacity as bankers.

Mr. FLORIO. As a practical matter, though, you do not really become involved. Your first lien, I mean your obligation—the hospital—every hospital that I have talked to says the first thing we have to do is pay our interest obligations. If we have to start cutting back on service because of a financial crunch, we do that.

So you really do not become jeopardized until the very end. They are about to close the doors, you are still getting your payments.

Mr. GREENE. Most financings are structured with some type of rate covenant so that hospital revenues must be generated sufficient to cover the debt service by a factor, say, of 20 percent, or something of that nature.

As long as they are in conformity with that rate covenant, we have no legal remedy.

Mr. FLORIO. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I regret that I was not able to be here during a part of the session. I have many farmers and constituents here with different financial problems and I had to talk with them for quite awhile.

I notice most of you gentlemen, well, some of you are from New York City, is that correct? And some of you are from the Ford Motor Company and Detroit, where you have an excellent health plan, I understand.

What does your health plan cost per person per year?

Mr. SHELTON. About $450 million——

Mr. CARTER. Per person?

Mr. SHELTON. $2,000 per person per year.

Mr. CARTER. $2,000. It is not over that?

Mr. SHELTON. No, sir, that is it.

Mr. CARTER. That is a pretty good expenditure.

In New York last year, or during the past year or so, you had a closure of thirty hospitals and 2,000 beds. How much has that saved your state?

Mr. GREENE. I do not have those figures, sir.

Mr. CARTER. What is your estimate?

Mr. GREENE. We can certainly try to locate them and present them to you at a later date.

Mr. ROGERS. That will be furnished for the record.

[The information requested was not available to the subcommittee at the time of printing.]

Mr. CARTER. I believe $20,000 to $30,000 is supposed to be saved for each hospital bed closed. That is something that has been said so much, that it has become almost accepted as an absolute truth. However, I am told that under certain conditions it is not correct, and I have been told so this morning.

For instance, in one of your hospitals in New York City, a certain number of beds were decertified but the building was still in fair condition. Would you want to do something with those extra beds, convert them in any way to other types of usage?

Mr. GREENE. Congressman, I am going to perhaps not respond to that. I do not feel that that particular question is within my area of expertise——

Mr. CARTER. Yes, yes, surely. That is a little bit out of the bondholders' expertise, I guess.

By the way, suppose we have a federally-funded hospital in your area, partially federally-funded, and perhaps your company has sold bonds for part of the hospital too, to raise money for it, and after 10 years, this hospital is decertified. How do you get your money back, if you had a twenty year retirement plan for your bonds?

Mr. GREENE. If that were the case, and if this bill passed without the suggestions which we have made today, our investors would lose the total amount of their investment at that point.

Mr. CARTER. After 10 years, even though the hospital is decertified, the hospital may be liable for return of some funds to the Federal government if the hospital's assets are sold to a for-profit firm. Is that not correct?

According to the law, it is.

Thank you, gentlemen.

Mr. ROGERS. Thank you so much for your presence. Your testimony has been most helpful and we may want to get back in touch with you.

Let me ask you this. Is Ford Motor Company thinking now of going into an HMO? We hear that they are considering that possibility?

Mr. SHELTON. We are involved with twelve HMO's at the present time and are looking at 35 others, but I think you are referring to the feasibility study that we commissioned in the Detroit area with Kaiser Advisory Services where we are studying the possibility of another community-based HMO in the Detroit area.

Mr. ROGERS. I think Reynolds has done this, I believe, in North Carolina.

Mr. SHELTON. Yes, sir.

Mr. ROGERS. Thank you so much. The committee is grateful.

The last witness this morning will be Dr. Sidney Wolfe, director of Public Citizens Health Research Group.

Dr. Wolfe, we welcome you to the committee.

STATEMENT OF SIDNEY WOLFE, M.D., DIRECTOR, PUBLIC CITIZENS HEALTH RESEARCH GROUP, ACCOMPANIED BY TED BOGUE, ATTORNEY

Dr. WOLFE. Thank you, Chairman Rogers. With me is Ted Bogue, an attorney with Public Citizens' Health Research Group who has been very active for the past couple of years in health planning.

Thank you for the opportunity to express our views on the need for changes in the Federal health planning program.

Consumers concerned about economic waste and maldistribution of resources in the health care system had great expectations for the new Health Systems Agencies created by Public Law 93–341. Those hopes have not been realized because of continued provider domination of the health planning process and inexcusable delay, indecision and timidity by HEW in implementing the program.

I was glad to see that Mr. Champion yesterday admitted that at least up until now there has been "inexcusable delay" in issuing regulations. Whether it will change, remains to be seen.

Two major kinds of problems with HSA's and State health planning and development agencies have become painfully apparent since passage of the Planning Act 3 years ago.

First: Public participation, support and accountability have been grossly inadequate in most HSA's because of unrepresentative and inadequately trained consumer board members and lack of community outreach, which are, in turn, the result of provider and professional domination. State agencies are even less accountable.

Second: Planning agency decisions have suffered from inadequate criteria, lack of jurisdiction and power over some kinds of expenditures and delays in compliance with Federal criteria.

Some of the amendments contained in H.R. 10460 will help to solve these problems and are consistent with suggestions the health research group previously made to the subcommittee. For example, self-perpetuation of HSA governing bodies through selection of new members by current members is prohibited, and broad participation in the selection process is required. The requirement for open meetings and data disclosure is extended to all HSA committees and a conflict of interest provision for HSA board members has been added. State agency decisions must be consistent with the State Health Plan.

State certificate-of-need programs are required to cover major medical equipment, such as CAT scanners, regardless of setting. States are required to develop a program within 4 years which would decertify any services which are found to be inappropriate.

In addition to these improvements, however, there are provisions in H.R. 10460 which either must be strengthened or are actually detrimental to the interests of consumers. More serious is the complete absence of badly needed major amendments proposed by us and other consumer groups. I will briefly mention several of the most critical. Our written statement will provide more details on other drafting changes we recommend, and the full written statement has been submitted.

One: Section 213, which requires HSA's for the first time to develop a program of support for members of the HSA governing body and committees is a small step in the right direction. However, this amendment completely ignores two crucial facts which call for much stronger action. First, there is a huge disparity between providers and consumers with regard to both their interest and their need for education. Most providers already have access to well-financed trade associations and are represented by full-time professionals. Consumers have no staff and no background, usually, in health planning concepts and jargon.

Second, there is also a compelling need for HSA's to educate and encourage activism among consumers in their area who are not already involved in the HSA. The denunciation, to put it mildly, suffered by health planning because of the recent national guidelines and the misinterpretation of them would not have occurred if the public had been better informed about health planning.

The law must, therefore, require the establishment of a full-time consumer support staff independent of the providers on the HSA board and with a substantial and irreducible minimum budget to

educate, assist and organize consumers, both inside and outside the HSA. The goal should be to provide resources for consumer advocacy at least equal to the resources already used for provider advocacy.

Two: HEW has broken its public promise to publish regulations to define the meaning of "broadly representative" of the population as it applies to the consumer component of HSA boards. This Subcommittee effectively endorses this inaction by failing to amend the statutory language. We support the legislative amendments proposed by the Consumer Coalition for Health and urge that HEW be required to publish proposed regulations within thirty days of enactment. I cannot believe that this subcommittee accepts the gross underrepresentation of low-income consumers and women which has predictably resulted from the present language and enforcement.

Three: Another abuse not remedied by the bill is allowing providers to vote for consumer candidates in HSA general elections. In several HSA's, hospitals and employees have nominated and elected their own slate of handpicked "consumers". This is a perpetuation of what we have seen too much of, namely nominal consumerism that, in effect, puts provider candidates under consumer banners.

Four: Although both HSA's and statewide health coordinating councils are required to have consumer majorities, State health planning and development agencies, which make the final decisions on certificate-of-need, can be, and often is, dominated by providers. This completely negates the concept of consumer domination and independent decisionmaking which underlies, or supposedly underlies, Public Law 93–641.

A majority of the State agency decisionmakers must be consumers, or nominated by consumers.

Five: The Certificate-of-Need requirements still have loopholes. Federal facilities are not required to be covered despite the substantial amount of services they provide to local residents. Nor are closure of services, which can have a serious adverse impact on low-income patients. HEW should also be given the authority to require coverage of equipment purchases that are less than $150,000, but have a major effect on operating costs, such as the recent evolution of so-called low-cost CAT scanners now being dumped on the market in order to avoid the planning law, and fetal monitors.

Six: Finally, Congress must deal with the problem of continued relatively unregulated purchases and construction in the interim period until State programs can come into compliance with Federal criteria. Mr. Waxman has just cited the recent study by GAO in which 92 percent of recently proposed expansion or construction programs were still approved, which is, I think, a classic example of how much advantage is taken by grandfathering and other kinds of provisions that avoid coverage of projects which are already planned.

The only rseponsible approach is to declare an immediate moratorium on all nonemergency capital expenditures until the State is in full compliance, followed by a dollar ceiling on annual capital expenditures. Otherwise, the health care industry will be able to neutralize certificate of need for several years with anticipatory spending before the axe falls.

I would like to add just one further comment which we have included in the full written remarks. HSA's should not be allowed to accept funds from health insurers and use them as matching Federal funds—section 208. When insurers are controlled by, or clearly allied, at the least, with providers, the HSA cannot be truly independent.

This section allows providers to indirectly do what they are prohibited from doing directly, and we certainly have enough evidence from the previous unsuccessful attempts at health planning under the old law wherein a substantial portion of the income for planning agencies was provided by providers. This is an impossible conflict of interest.

At this point in time, it cannot be said that the health insurance industry is anything other than a banking operation for providers so that to allow them, as opposed to the "true providers" to contribute to the income to HSA's, we do not believe is a good idea.

Finally, I would like to submit for the record, in addition to these detailed amendments, a copy of a book which we wrote, which has been distributed to thousands of consumers in HSA's and which we think really is the basic issue here. The book is called "Trimming the Fat off Health-Care Costs: A Consumer's Guide to Taking Over Health Planning."

The amendments we have proposed are really amendments to facilitate what is long overdue, consumers taking over health planning.

Thank you and we would be happy to answer any questions.

[Testimony resumes on p. 357.]

[Attachments to Dr. Wolfe's prepared statement follow:]

PUBLIC CITIZEN'S HEALTH RESEARCH GROUP
COMMENTS ON H.R. 10460
HEALTH PLANNING AND RESOURCES DEVELOPMENT
AMENDMENTS OF 1978

The Health Research Group supports the following amendments contained in H.R. 10460:

1. HEW has authority to limit the funding and functions of fully designated HSAs (§205). This authority will allow HEW to compel HSAs to improve their performance without threatening termination--a step which is unlikely ever to be taken.

2. Labor unions are defined as major purchasers and thus required to be represented on HSA boards (§209(a)(1)).

3. Self-perpetuation of HSA boards is prohibited, and HSAs are required to provide for broad public participation in the selection process (section 210). This will eliminate one of the chief abuses in the initial composition of HSA boards.

4. The requirement for open meetings, notice of meetings and disclosure of data is extended to all HSA committees (§212(b)). However, the burden should be on the HSA rather than members of the public to develop a mailing list of affected persons and groups who will be given regular notice of meetings. Also, these requirements should be extended to Subarea Advisory Councils (which are not generally "appointed by" the board or executive committee).

5. The members of HSA boards and committees must comply with a conflict of interest provision (§214). We suggest, however, that past conflicts also disqualify members from particular cases, i.e., the language should be "...with which such member has or has had any...relationship." Loyalty to an institution continues after the relationship ends. Also, the relationships should include "debtor" and "medical staff." A doctor with staff privileges at a hospital does not fall within any of the stated categories.

6. The same public hearing requirements apply to the Annual Implementation Plan as to the Health Systems Plan (§216(e)).

7. The requirements in §218(a) for annual review of the progress of a project granted a certificate of need, a specified maximum on the amount of capital expenditure, and consistency with the State Health Plan are needed improvements.

8. The extension of mandatory certificate of need coverage to all major medical equipment is long overdue (§1531(7)). However, in order to eliminate any doubt on the matter, we recommend that it be made explicit that non-institutional settings such as private physician offices are included.

9. We support the elimination of any discrimination against Health Maintenance Organizations (§218(b)(3)(B)). However, it is not clear under what circumstances ambulatory facilities are covered. Are they covered if built by a hospital but not if they are built by an HMO or are free-standing?

10. Section 218(b)(6) replaces a needed review criterion on efficiency and appropriateness of existing facilities which was eliminated by HEW from its regulations.

11. Decertification is an authority which state agencies must clearly have in order to be effective (§219(b)). However, future development of both substantive and procedural criteria must carefully prevent discrimination against public and inner city facilities which serve the poor.

The following provisions should be modified to strengthen them:

1. The problem with the non-metropolitan residents language changed in §209(b)(2) is not the percentage but rather the definition of "non-metropolitan." Residents of remote rural underserved areas must be represented. We recommend that "medically underserved" areas as defined by HEW have mandatory representation (which would also include inner city areas).

2. Section 209(d)(2) concerning which family members are indirect providers should include every relative in the provider's household whether or not they are spouses.

3. As noted in our testimony, HSA support for consumers must go far beyond the requirements of §213. Consumer board and committee members must have special access to their own full-time staff independent of providers and the HSA technical staff. This consumer staff must prepare analyses in lay terms of the pros and cons of particular projects under review. Also, the consumer staff must have the resources and be required to conduct public information and consumer organizing activities for those not already involved in the HSA to compete with provider trade associations.

4. While we have no objection to the "batching," priority-setting approach to review contemplated by §218(b)(4), the language must require HSAs to actually use this approach to qualify for the one-year time period. Otherwise, they should be limited to 90 days.

5. Section 219(a) should allow HEW to require HSAs to conduct appropriateness review for major medical equipment, such as CAT scanners, in non-institutional settings, including physician offices.

There are several provisions we oppose. We urge that they be eliminated.

1. HSAs should not be allowed to accept funds from health insurers and use them as matching for Federal funds (§208). Where insurers are controlled by, or clearly allied with, providers, the HSA cannot be truly independent. This section allows providers to indirectly do what they are prohibited from doing directly.

2. Former indirect providers must not be allowed to become consumers as soon as their indirect provider status ends (§209(d)(1)). This would allow the Executive Director of a county medical society to leave that position and immediately become a consumer on the HSA board. To the contrary, the waiting period should be extended to five years.

3. Ownership transfers or lease arrangements, even those which involve no change in services or capacity, should not be excluded from mandatory certificate of need coverage (section 218(b)(3)(A)). Who owns or operates a facility can have a major effect on the quality and appropriateness of services rendered, especially for nursing homes. Planning agencies must have the authority to look at the owner's record in other facilities.

4. Section 225 provides that the health planning amendments will not be effective until a year from enactment--mid-1979 at the earliest. Most of the changes made by the bill are years overdue, and there is no reason to allow the problems to persist. The amendments should be effective within three months, with exceptions only for those requirements which actually require time to implement. Most of the amendments would not in any way disrupt the ongoing activities of the HSA. Even those which cannot be done immediately, such as training for board members, should be started without delay.

5. Loans and loan guarantees under Title XVI should not continue to be available for construction of new inpatient facilities (§301(b)), even where there is rapid population growth or where some beds have been closed. All regions now have some excess capacity to absorb population growth. There is virtually no possibility of closing too many hospital beds in any area.

The following provisions in the law are seriously in need of amendment but are completely absent from the bill:

1. As noted in our testimony, HEW has failed to publish promised regulations defining "broadly representative" of the population as it applies to the consumer component of HSA governing bodies (§1512(b)(3)(C)(i)). No mention is made of these regulations in HEW testimony before this Subcommittee or in the list of regulations under development. The failure of this Subcommittee either to compel HEW to issue regulations or to amend this provision in the statute is an effective endorsement of the current composition of HSA boards. The extreme and pervasive under-representation of women, the poor, the medically underserved, and those with special health problems completely undermines the effectiveness of and support for most HSAs. It is imperative that Congress act now to correct this problem by adopting amendments similar to those proposed by this group, the Consumer Coaltion for Health, and legal services groups.

2. Section 210 concerning selection of HSA board members should prohibit providers from being eligible to vote for consumer candidates in a general membership election. Providers, especially hospitals, have "packed" HSA elections in some areas, such as Los Angeles and Arkansas, by giving their employees time off and transportation to polling places to vote for "consumer" slates handpicked to be sympathetic to providers. Consumers should not represent provider interests.

3. Section 212(b) should be expanded to require that all HSA committees and SACs have consumer majorities. (Section 1512(b)(3)(C)(iv) now requires HSA committees to comply with all composition requirements "to the extent practicable.") In some HSAs, "technical" task forces dominated by providers have developed important sets of review criteria.

4. The law now provides no way for consumers to appeal HSA decisions which are followed by the State Agency. We recommend that any person who has given oral or written testimony or voted as an HSA member on an application under review have standing to appeal the decision to the State reviewing body. Otherwise, there is no way for anyone to challenge an arbitrary approval of an unnecessary project where the HSA and the SHPDA agree.

5. State agencies, which make final certificate of need and appropriateness review decisions, are not required to have consumer majorities. The individual or group which makes the decision is often dominated by providers. We recommend that the SHPDA decision-makers have a majority

consumers or nominated by consumers and that they be appointed for fixed terms rather than serve at the pleasure of the Governor.

6. We have proposed that HSAs and State agencies pay the costs of intervention for consumer groups which are technically qualified, have no vested interest, and are otherwise unable to afford to prepare analyses of projects under review.

7. As noted in our testimony, there ought to be a moratorium on non-emergency capital expenditures until States are in full compliance with certificate of need requirements and have completed their State Health Plan and State Medical Facilities Plan. After that, there should be a dollar ceiling. This is similar to the approach taken in the Hospital Cost Containment bill which was approved by the Senate Human Resources Committee last year.

8. There are still several gaps in mandatory coverage under State certificate of need programs. Federal facilities are entirely excluded. It is discriminatory to cover other facilities which serve out-of-area residents and provide specialized services (e.g., children's hospitals) and exclude those operated by the Federal government. At a minimum, the Federal agency should have to provide public, detailed, written justification for not following an HSA or SHPDA planning decision.

Closure of services, either voluntarily through incentive payments or by decertification, should be reviewed by HSAs and State agencies according to strict criteria which assure that public and inner city hospitals are not discriminated against and low-income patients are not denied access to necessary services.

Finally, HEW should be given authority to require review of equipment which doesn't meet the capital expenditure threshold but nevertheless has a major impact on operating costs. (Such a provision was considered during markup of the Hospital Cost Containment bill in this Subcommittee last year.) Examples are the CAT scanners now being marketed for less than $150,000 and fetal monitors.

Public Citizen

TRIMMING THE FAT OFF HEALTH CARE COSTS: A CONSUMER'S GUIDE TO TAKING OVER HEALTH PLANNING

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ACKNOWLEDGEMENTS

Several people made important contributions to the preparation of this handbook. Dr. Sidney Wolfe is the source for many of the ideas in the book and provided major editorial assistance. Colette Thomas oversaw all the clerical work involved in completing the book and proofread the entire manuscript. Mary Frances Walsh typed and put together the manuscript, including many revisions made necessary by the author's changing his mind at the last minute. Susan Ulinski was responsible for finally getting the book printed. My thanks to all of them for their patience and hard work.

November 8, 1976 Ted Bogue

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INTRODUCTION

This Handbook is about the role of consumers in the health planning agencies, called Health System Agencies or HSAs, created by the National Health Planning and Resources Development Act of 1974, popularly known as Public Law 93-641. What is health planning and why should consumers spend time and energy participating in it? Why not leave health planning to the "experts"--doctors and hospital administrators? In fact, consumers have much to gain by being active in health planning and much to lose by letting others, especially providers,make planning decisions.

Health Care Costs You Much More Than You Think

Health planning can have a significant effect on health care costs. Families are now forced to spend a significant part of their income to obtain health care. During fiscal year 1975, total national health care expenditures were $118.5 billion. The total has now risen to a figure in the neighborhood of $140 billion a year. This means that the median annual family expenditure on health care is probably in the range of $1800 to $2000, which represents roughly 13-14% of the current median annual family income of about $14,000. In other words, a typical family spends about one dollar out of every seven or eight it earns in income to buy health care. Family wage-earners have to work about seven weeks each year just to pay the health care bills for themselves and their dependents. And the impact increases as family income goes down; low-income workers have to spend a much higher percentage of their income for health care. Equally disturbing is the rate at which health costs are increasing. For the past twenty years, health costs have been increasing much faster than your income and thus taking a bigger and bigger bite out or your paycheck.

Most families do not realize how much they actually are paying for health care because most health expenditures are indirect. You very seldom pay out-of-pocket for health services when you receive them, as you do for groceries and other family expenses. Besides direct cash payments, you pay health insurance premiums, which, if you are a member of an employee group plan, are usually deducted from your pay check before you receive it. Other health care costs are even more hidden. When employers pay for part or all of your health insurance, the cost to them will either be taken out of your wages and/or added to the prices of the employer's products. Employee health care costs also add to the prices of the other consumer products you buy. Finally, a substantial percentage of the taxes you pay--Federal, state, and local--is used to purchase health care services or fund other health programs. Thus, every penny that is spent for health care ultimately comes out of your pocket and, as mentioned above, the total annual cost to you and your family is likely to be about $2,000 a year.

The Billions Wasted by Providers Make Your Premiums Rise

How can health planning reduce the amount you have to pay for health care without impairing the quality of the services you need? To appreciate the cost-saving potential of health planning, you must first understand why health costs are so high and going up so fast. The fact is that much of the 140 billion dollars we are now spending annually on health care is wasted. For instance, the U.S. now has nearly a million general hospital beds. On an average day fully a quarter of these million beds sit empty. A hospital bed now costs about $70,000 to build. Maintaining an empty bed costs about $20,000 per year--at least half as much as maintaining an occupied bed. If 150,000 of the 250,000 empty beds were eliminated (which would still allow 100,000 beds--about 12% of the total--to be available for turnover and emergencies), $3 billion per year would be saved nationwide and you would pay about $85 less for an average hospital stay.

And this saving is only the "tip of the iceberg". As long as there are plenty of surplus hospital beds, doctors will tend to inappropriately hospitalize many of their patients. A substantial percentage of the patients occupying the other 750,000 hospital beds each day don't need to be there. Their hospitalization is either completely unnecessary or has been extended too long: or their care could have been provided more cheaply in a nursing home or in an outpatient setting. In HRG's book, the $8 Billion Hospital Bed Overrun, it was estimated that at least a third (and perhaps as many as one half) of all hospital patient days could be saved by more appropriate utilization of hospitals. The dollar savings from such reduced hospitalization would be two or three times as great as the saving from eliminating idle beds. The two together could potentially save the average family between one and two hundred dollars a year in health care costs.

There are also other unnecessary health care costs. Many of the services provided to hospital patients may not be needed and/or may cost patients too much. Because of their desire to attract or keep medical staff members and to enhance the reputation of their institution, hospital administrations buy high-technology equipment and facilities, such as $500,000 CAT scanners and open-heart surgery units which they don't need or could share with other hospitals. The cost of buying and maintaining such unnecessary equipment must be added to the bills of patients on whom it is used and/or to the bills of all the patients in the hospital and, of course, adds to your health insurance premium. Ironically, patients who receive unnecessary procedures using this equipment are sometimes charged so much that hospitals and doctors are able to not only pay for the machine but also make a profit.

Consumer Health Planning Can Save You Money and Improve Care

These examples are not the only kinds of waste in the health care delivery system. They are discussed to illustrate that a significant part of your health care dollar is being spent on facilities and equipment which do not improve the treatment of patients and thus have no effect at all on people's health. In a better planned and organized and more efficient health care system, your family could save hundreds of dollars a year on health care bills, not only in lower health insurance premiums but also in higher wages and smaller increases in taxes and prices, without any reduction in the quality or accessibility of needed services.

An equally important reason for getting involved in health planning is to improve the primary care services in your area. Many people, particularly those in medically underserved inner city and rural areas, have trouble obtaining good quality preventive and ambulatory care services despite the billions of dollars being spent on health care. Too much of your premium money and taxes is spent on fancy medical centers, more hospital beds, and sophisticated equipment and too little is spent on community outpatient facilities.

Providers Have Flunked the Health Planning Test

What will Health Systems Agencies (HSAs), particularly their consumer members, be able to do about all this? Before discussing the powers of HSAs, it may be helpful to briefly discuss the history of health planning in the U.S. leading up to the passage of the Federal law which created HSAs.

Local hospital organizations recognized as long as 50 years ago that cooperation among hospitals in a local area might be helpful in dividing up the patient market among the facilities so that each could do a reasonable amount of business. However, the first governmental involvement in health "planning" did not come until after World War II with the Federal Hill-Burton Act. Though this law was primarily and successfully designed to provide Federal funds for the construction of more and bigger hospitals, the state agencies which administered the program had to develop a plan based on public need to determine which areas and which facilities would get the Federal money. The Federal government and the hospital industry in the late fifties and early sixties made noises and published reports about the need for hospital planning but little happened until the mid-sixties when Federal legislation launched the Regional Medical Program (RMP) and the Comprehensive Health Planning (CHP) program. RMPs were initially designed to bring new medical breakthroughs in treating cancer, stroke, and heart disease to local communities and CHPs were supposed to bring about a "Partnership in Health" between providers and consumers, which would result in a more rational, more responsive delivery system. The failure of either of these programs to achieve their goals is discussed throughout this report, but

suffice it to say here that RMPs and CHPs have usually been controlled by providers and have uniformly failed to prevent hospitals from overbuilding, duplicating services, and buying unneeded, expensive equipment. Planners also were unsuccessful in encouraging the development of adequate primary care in underserved areas.

As health care costs soared upward after the passage of Medicare and Medicaid in 1965, bureaucrats and politicians became convinced that the health industry had to be regulated as well as financed by the government. In the early seventies, many states passed "certificate of need" laws, which required a state agency to certify that hospital construction was needed before a facility could be built or expanded. In 1972 Congress passed legislation, which established a Federal certificate of need program (called the "1122" program) under which states could prevent a facility from getting Medicare and Medicaid reimbursement for unnecessary capital expenditures. (These certificate of need programs usually employed CHP agencies for local review). The same law created Professional Standards Review Organizations (PSRO), which are supposed to prevent unnecessary hospitalization under Medicare and Medicaid. Some states established rate-setting commissions for health care facilities to determine how much the state and Federal governments and sometimes health insurance companies as well could pay for various health services. Despite all these attempts at regulation hospital building and buying has continued almost unabated. The number of hospital beds is still increasing faster than the population; the cost of health care, and especially hospital care, continues to increase much more rapidly than other prices. The flow of consumer dollars to health providers has hardly been interrupted. And many areas still suffer from grossly inadequate primary and ambulatory care. The providers may be doing more paperwork, but there is no evidence that consumers are getting better health care for their additional dollars.

The Health Systems Agency: A Potential Source of Consumer Power

Because of the failure of CHP and RMP to "rationalize" the delivery system, Congress in 1974 decided to revamp the health planning structure. The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) replaced RMP and CHP agencies with the Health Systems Agency (HSA) at the local level (which generally covers larger areas than the old CHP units) and a State Health Coordinating Council (SHCC) and State Health Planning and Development Agency (SHPDA) at the state level. The SHPDA must administer a certificate of need program based on recommendations from HSAs. HSAs must prepare a Health Systems Plan (HSP) and Annual Implementation Plan (AIP), which will become part of the State Health Plan (SHP) approved by the SHCC. The HSA will also review and approve or disapprove each proposed use of Federal funds for health programs in its area and make recommendations as to whether facilities are being appropriately utilized. Both the HSA and the SHCC must have consumer majorities.

The definition of "provider" has been considerably broadened and HSAs are prohibited from accepting funds from providers or groups of providers. Finally, there is a greater emphasis under PL 93-641 on public notice and hearings, open meetings, and public disclosure of information. At least on paper, HSAs are required to make their decisions openly and are designed to prevent domination by providers.

HSAs give consumers the opportunity to stop the waste of their insurance premiums and to change the way in which health care is delivered in their community. Much of the HSA's power is negative--it can recommend against the construction or expansion of a facility, the offering of a new service, or the funding of an applicant for a Federal grant. Through effective use of these powers, consumers can save insurance and tax dollars which otherwise would be spent on wasteful construction and expensive machines of little or no benefit to patients. While the HSA cannot directly build facilities or fund services, it can have great influence on the nature and manner of delivery of services offered in its area. It can put conditions on its approval of proposals related to appropriate utilization, provision of care to the medically underserved, sharing of equipment and facilities, reporting of data, etc. When the HSA disapproves a proposal, it can suggest how the proposal could be changed to satisfy its criteria. It can offer technical assistance and make grants to groups wishing to develop such projects as neighborhood health centers, health maintenance organizations, or health education programs. In short, by combining its legal authority with assistance to those trying to improve health services, a consumer-run HSA can redirect the flow of consumer dollars away from wasteful, high technology facilities and services toward improving less costly primary care and return the savings to the consumer's pocket.

As indicated by the discussion of the history of health planning, physicians and hospitals have always dominated health planning, even after CHP agencies were required to have consumer majorities. The "expertise" of providers has clearly not resulted in an efficient, effective, responsive delivery system. Provider control of the health care system is the problem, not the solution. The public has been willing to accept a degree of "self-regulation" in the health care industry which it would not tolerate in other sectors of the economy. Having providers sit on the boards of agencies which have regulatory authority over them is like having airline executives sit on the Civil Aeronautics Board, which determines airline rates, or a utilities executive sit on a state utilities commission. Thus the "partnership in health" concept is tantamount to saying the health care industry should not be regulated at all. The fact that most hospitals are non-profit and theoretically produce services which are "good" for people does not mean that providers will not pursue their own private, special interests. Doctors, hospital administrators, and hospital directors are as motivated by the desire for prestige, power, and financial advantage as other economic

interests. Only occasionally do these incentives coincide with maximizing health benefits per dollar for consumers.

In the past health consumers have had no more power over the cost and delivery of health services than individual workers had over their wages and working conditions before they unionized. Accordingly, health planning must now be viewed as an adversarial process, not a partnership. Employers paid little attention to employee grievances until workers had the right and the willingness to strike. Likewise, the responsiveness of health providers to consumer complaints about cost and quality will never go beyond public relations until consumers are willing to use the health planning process to challenge provider waste and insensitivity.

This handbook is being sent to labor unions who have made efforts to improve services and control costs for their health plan beneficiaries and to all designated HSAs and State Health Planning and Development Agencies as well as to individual consumers and consumer groups. We regard it as the responsibility of all these groups to be aggressive consumer advocates in the health planning process. Consumers and unions have an obvious stake in the cost and quality of health care but are only beginning to make their influence felt. While many if not most professional health planners have taken seriously their responsibility to serve the public, they also have usually been hampered by a lack of resources, data, legal authority, and political support in their efforts to improve the health care system. Planners will already be familiar with most of the legal requirements and planning issues and problems discussed in this report. However, we think it is important for planners to read the report to remind themselves how much consumers have to learn and how planners should be working with and educating them. Planners in turn, need the support of consumers on their board, especially in opposing unmeritorious provider proposals, and consumers are dependent on planners to inform them about technical issues and provide them with data. In other words, unions, planners, and consumers have much to gain and nothing to lose by working together to compel providers to eliminate waste and improve their delivery of services.

WHAT CONSUMERS SHOULD BE DOING NOW

By the time you read this report, Health Systems Agencies (HSAs) will have been designated by HEW in every health service area in the United States (with the possibility of a few inexcusable exceptions). Many of you have already been involved to various degrees in the formation of the HSA. In a few exciting cases, you may actually be running the show. Unfortunately, we know that some of you were unsuccessful in getting a truly consumer-oriented agency designated. But regardless of how sympathetic (or unsympathetic) your HSA is now to consumers and consumer interests, the opportunity for making the HSA accountable to the public is not yet lost. For at least one year and possibly two years from the date of designation, the HSA will be only conditionally designated.

The Governor, the Statewide Health Coordinating Council (SHCC), and the HEW regional office will be taking a look at the performance of the HSA before it can be fully designated. It is essential that consumers closely monitor the operation of the HSA during the conditional period to assure that it at least lives up to all the obligations to consumers imposed upon it by the Federal statute, Federal regulations, and its designation agreement with HEW. The HSA should go far beyond these minimum criteria in the direction of consumer accountability.

The single most important factor to bear in mind in dealing with your HSA is one of attitude. Consumers should not just be participating in health planning; they should be doing the planning themselves. The HSA staff should be working for you--not for the government and certainly not for the providers. The providers should be represented in the HSA only for the purpose of facilitating the flow of information to the public and defending their actions and proposals in terms of how beneficial they are to you--the health consumer and taxpayer. In other words, consumers should be deciding how to best organize the delivery system to get the most for their health care dollar. Providers are involved only to account for how the care they deliver conforms to the criteria set by consumers and to better cooperate among themselves toward that end. Consumers should not be advising planners or providers; planners and providers should be advising and informing consumers, who finally decide what the health system should look like.

Following is a list of suggestions for action by health consumer groups which include both the enforcement of legal requirements that the HSA do business in the public eye and develop detailed plans and criteria for the area and more strategic approaches to influencing HSA action. Details on each suggestion follow the list.

SUGGESTIONS FOR CONSUMER INVOLVEMENT IN HSAs

1. Identify and maintain constant contact with an HSA staff person or persons who are responsible for or at least sympathetic to consumer involvement.(page 9)

2. Obtain and familiarize yourself with copies of all documents governing the operation, structure, and procedures of the HSA.(page 9)

3. Make certain the consumer representatives on the HSA Board and other HSA committees actually have no conflicts of interest, accurately reflect the demographic composition of the health service area, and are willing to be active and aggressive in confronting proposals by providers. (page 10)

4. Get your group on the mailing list for all notices and information sent out by the HSA. (page 12)

5. Make certain consumers from your group are represented and prepared at all meetings and hearings. (page 13)

6. Adopt a data policy which requires reporting to the HSA of all relevant information by individual providers and guarantees that all information, documents, internal reports, etc., are disseminated or readily available to the public. (page 15)

7. Be actively involved from the earliest stages in the initial development of the Health Systems Plan (HSP), the Annual Implementation Plan (AIP), and the procedures and criteria for certificate of need review. No proposals for new inpatient hospital construction or major capital equipment should be granted a certificate of need until these three documents are completed and approved. (page 21)

8. During the HSA's period of conditional designation, be sure to document and complain about--informally, in written comments, and at public hearings--all instances of unresponsiveness to consumer interests. Copies of your complaints should be sent to the HSA Board, the Governor, the Statewide Health Coordinating Council (SHCC), your Congressperson(s), and Public Citizen's Health Research Group. (page 27)

1. Identify and maintain constant contact with an HSA staff person or persons who are responsible for, or at least sympathetic to, consumer involvement.

In comments on the proposed HSA regulations, HRG suggested that each HSA be required to employ at least one full-time consumer resource person, who would be responsible for organizing, educating, responding to requests for data and information from, and notifying consumer groups of all HSA meetings and hearings. Our advice was not heeded, but there is no reason why the HSAs should not be doing this on their own. If your group doesn't yet have sufficient voting power on the HSA Board to formally hire and designate a staff person to be responsible for consumer education, then you should informally approach various staff members until you find a person or persons who are sympathetic to consumer participation and whom you can trust. Keep in constant contact with these staffers and make sure they keep you informed. If there is no one on the HSA staff who is responsive to consumers and willing to spend time with you, your group will be at a large disadvantage from the beginning. Rest assured that hospital associations and medical societies will be aggressively cultivating sources of inside information on the HSA staff to further their own interests.

Once you have found such a resource person, ask him or her to come to meetings of your group, perhaps to make regular periodic reports on the activities of the HSA. Encourage him or her to spend time in the communities among all racial and ethnic groups, doing education and responding to questions about the law, the development of the Health Systems Plan(HSP) and the Annual Implementation Plan (AIP), the procedures and criteria for performing certificate of need review, etc.

Perhaps the best approach is to organize an independent consumer organization staffed by someone paid by the HSA but accountable to the governing board of the consumer group (which might include some or all of the consumer members of the HSA Board) rather than to the HSA Board. The staffer should be responsible for finding and informing consumer representatives for all HSA committees and task forces, making sure consumers are represented and prepared for all meetings and hearings, and all of the other activities mentioned above. The HSA work program, discussed under Suggestion #2, should be revised to reflect these responsibilities.

2. Obtain and familiarize yourself with copies of all documents governing the operation, structure, and procedures of the HSA.

There are at least three important sets of documents you should be sure to have:

(a) The HSA's final application to HEW, upon which designation was based. There will also be a conditional designation agreement

between the HSA and HEW which may be nearly identical to the application (the only differences would be provisions in the agreement which correct whatever deficiencies in the final application had not been corrected at the time of designation). The agreement is likely to be a voluminous document. It is important because it sets forth the proposed structure, procedures, and work program for the HSA during the period of conditional designation. In particular, be sure you are familiar with (1) the Articles of Incorporation and by-laws (or, in the case of a public or local governmental HSA, the statute, ordinance, and rules or regulations which govern the HSA), which must be a part of the agreement and which describe how members of the governing board and committees are chosen; (2) the work program of the HSA, which describes what the HSA proposes to do during the conditional period and when (look especially for any plans about consumer organization, education, and information); (3) a section of the application describing the organization of subarea advisory councils; (4) a summary of the comments made concerning the proposed composition of the governing board and the work program at public hearings prior to submission of the application; and (5) a list of the members of the HSA Board and Executive Committee, information about them, and the method by which they were selected.

(b) Copies of the Federal Law (Public Law 93-641) and the Federal regulations relating to HSAs and the proposed regulations on certificate of need review (published respectively in the March 26, 1976, and March 19, 1976, Federal Registers), which should be available from the HSA staff. The law and the regulations are long and complicated and many of their provisions will be repeated in the designation agreement, but you should have them for reference for instances when you have some doubt that the HSA is complying with all legal requirements. Much of the rest of this report will highlight the provisions which will be of most importance to consumers.

(c) Drafts of the initial Health Systems Plan (HSP), Annual Implementation Plan (AIP), and the procedures and criteria to be used for certificate of need review. More about this under #7; these documents cannot be adopted until public hearings are held and public notice is given. The important thing is to obtain and make your views known on the earliest drafts; again, you can be sure that providers will be devoting a great deal of time and energy to such review and comment.

3. Make certain the consumer representatives on the HSA Board and other HSA committees actually have no conflicts of interest, accurately reflect the demographic composition of the health service area, and are willing to be active and aggressive in confronting proposals by providers.

The statutory requirements of between 50 and 60% consumers and appropriate demographic composition (discussed below) apply not only to the governing board of the HSA, but also to the Executive Committee

(which must be created if Board membership exceeds 30), subarea advisory councils, and all other committees, subcommittees, and advisory groups appointed by the Board or the Executive Committee. In other words, no group established by the HSA to advise, make recommendations, or make decisions can legally be dominated by providers or by "elitist" consumers.

Under PL 93-641 a "consumer" is defined as any person who is not a "provider", and "provider" is very broadly defined to emcompass "indirect providers". This latter category includes any person who is on the board of directors or trustees of, or derives more than one tenth of his gross income from, any corporation or organization which either provides health services directly or supplies medical goods or services to an organization which does. A direct or indirect provider's spouse or any member of his or her immediate family is also a provider. Thus, for example, a doctor's spouse, a banker who is a hospital trustee, an employee of a drug company, and a lawyer who represents hospitals would all be providers under the statutory definition. Make sure that none of the "consumer" members of the HSA Board, the Executive Committee, the subarea advisory councils, or any committees or task forces have such conflicts of interest.

The statute also requires that the consumers represented on all of the above-mentioned groups be "broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care." In the preamble to the final HSA regulations, HEW said that "although the term 'broadly representative'does not necessitate an equal proportion, it does indicate that the consumer majority should roughly approximate, in its representational aspects, the whole population of the health service area." The HSA application should contain sufficient information to determine whether any population group--for example, low-income people, blacks, Spanish-speaking people, women, the elderly, residents of remote rural areas or the inner city--is underrepresented among the consumer majority on any of these bodies. If such an imbalance exists, new members who are more representative should be selected.

In addition to the HSA governing board and Executive Committee, the two final decision-making bodies at the HSA level, the statute permits the creation of subarea advisory councils "to advise the governing body of the agency on the performance of its functions". Because many HSAs cover large geographic areas (in some cases whole states) or large populations (in some cases several million people), the subarea advisory councils will often be necessary to assure consumer input at the local level. The HSA should set up the subarea councils to make recommendations to the HSA about any decisions which concern its area, particularly certificate of need decisions, the relevant sections of the Health Systems Plan (HSP) and the Annual Implementation Plan (AIP), and nominations to the HSA Board and Executive Committee. Unless the HSA utilizes these subarea groups, some local groups may not have a voice in decisions directly affecting their communities.

Neither the law nor the regulations requires any particular method of selecting Board and committee members. Any method is permissable so long as the composition of the resulting Board meets the statutory requirements. In some HSA's, Board members are elected by residents of the health service area who have expressed an interest and thus become members of the HSA. In others, the initial Board members were volunteers who had been active in preparing the application or who were serving on existing health planning councils or boards. In such HSA's new members are chosen by members already sitting on the Board. The latter method is less open and democratic and may result in perpetuation of an "in-group" of consumer representatives who are unwilling to agressively challenge provider proposals or are inactive.

If your HSA does not already have a selection process for Board members (and members of other committees) which allows consumer groups to thoroughly examine the qualifications and attitudes of people who wish to be on the Board, (and which assures broad representation, as discussed above), you must work to change it. It is vitally important that the consumer representatives on the HSA be willing to spend the time and energy to go to every meeting and hearing and be prepared to critically question proposals and approaches put forth by providers. Perhaps the best strategy is to independently organize and support these consumer representatives, as suggested in #1 above, to monitor their performance and to help them prepare for meetings. In the past, health planning has failed to represent the real interests of consumers because such consumer representatives were inactive, uninformed, unprepared, or simply too willing to acquiesce to provider "expertise". It is the responsibility of consumer groups not to allow this kind of caving-in to continue any longer. It cannot be afforded.

4. Get your group on the mailing list for all notices and information sent out by the HSA.

The statute and the regulations require the HSA to provide adequate notice to the public of all meetings of the HSA Board and Executive Committee, all public hearings concerning the Health Systems Plan (HSP) and certificate of need review, the consideration of proposed procedures and criteria for certificate of needs, the beginning of certificate of need review of a particular application, and, periodically, the status of all pending certificate of need reviews. At one of the early meetings of the HSA, your group should propose that the HSA periodically (monthly or perhaps semi-monthly or even weekly) issue a newsletter which contains information about all of the above-mentioned activities and also covers all meetings of subarea advisory councils, and all other HSA committees, task forces, and advisory groups, the consideration of the proposed Annual Implementation Plan (AIP), all meetings of your group and any other consumer groups concerning health planning, and contains data regularly collected by the HSA from providers.

Second, you must urge the HSA to compile a mailing list for the newsletter which includes your group, labor unions, any other consumer groups interested in health planning, and other individual residents of the area who have expressed an interest in the activities of the HSA (all people who have served on any HSA committee or who have testified at public hearings, for example).

Equally important is to assure that the HSA disseminates copies of important documents and proposed documents to consumer groups, as soon as they are written. Included in this category would be drafts and final versions of the Health Systems Plan, the Annual Implementation Plan, plans and projects based on the AIP, the procedures and criteria to be employed for certificate of need and other types of review, the new institutional health services covered by certificate of need review, copies of the Articles of Incorporation and by-laws (or analogous statutes or ordinances for public HSA's) and all proposed revisions to them, minutes of meetings of the HSA Board and Executive Committee, and testimony at hearings on the Health Systems Plan and the Annual Implementation Plan. It may be appropriate to use a smaller mailing list for such materials, but nothing should be disseminated by the HSA (to anyone, especially providers) without providing notice in the newsletter of such distribution. The HSA should also have a written policy for promptly responding to all requests for the sending of additional copies to other groups or individuals. (See #6 below).

In addition to all of the above notices and distribution of material, which the HSA is either required to do or should be doing on its own initiative, the statute and regulations also require the HSA to provide newspaper notification of all meetings of the Board and the Executive Committee, all public hearings on the Health Systems Plan and individual certificate of need reviews, and the availability of proposed Health Systems Plans and proposed procedures and criteria for certificate of need review. It is important that your consumer group get the HSA to go beyond such minimum legal requirements by using the newsletter and by broad and early dissemination of drafts of important documents being considered by the HSA. The HSA must also adopt a written policy that nothing will be made available or disseminated to any provider or provider group unless it is also made available or disseminated to all others on the mailing list and notice of its availability is provided to the public.

5. Make certain consumers from your group are represented and prepared at all meetings and hearings.

The governing body of the HSA must meet at least once in each calendar quarter of the year. They must also meet at least twice more unless the HSA has an Executive Committee which has met at least twice during the year. An Executive Committee must be created if the membership of the governing body exceeds 30; it has the authority to take any action which should have been taken by the HSA Board

except amending the Articles and by-laws and making decisions about the Health Systems Plan (HSP) or Annual Implementation Plan (AIP). Neither body can act unless a quorum, which must be at least one half of the members, is present and a majority of those present and voting decide in favor of the action. Adequate notice of all meetings of either group must be provided by the HSA (see #4 above) and all meetings of either must be open to the public.

All important decisions regarding the HSP, AIP, adoption of procedures and criteria for review, and individual certificate of need applications will be made at these meetings. Because a quorum is only one half of all members, it is possible for providers to outnumber consumers at a particular meeting if most or all the providers are there and several consumers do not attend. It is by such ploys that providers in the past have been able to advance their own interests despite requirements for consumer majorities. Therefore, it is critical that consumer representatives attend every meeting. Since (unfortunately) in most HSA's the consumer majorities are close to the legal minimum of 51% and since the provider representatives are usually full-time professionals who attend every meeting, the absence of even one consumer may convert the consumer majority into a helpless minority.

Although consumer majorities are required on all HSA Subarea Advisory Councils, committees, and subcommittees, there is no legal requirement that all meetings of such groups be open to the public. You should work to amend the by-laws, if necessary, to require that all HSA meetings of any kind be open to the public. Only if meetings are open can consumer groups monitor the performance of their own representatives (as well as that of the providers).

Another, perhaps more important, problem is the possibility that all or some of the consumers serving on the Board or other committees will not be adequately prepared or inclined to challenge the arguments made by providers at meetings and hearings. In the Comprehensive Health Planning (CHP) Program consumers all too often yielded to provider pressure because they were too timid or uninformed to expose the fallacies of provider proposals and data. Because they were not able to speak or understand the jargon of hospital and nursing home professionals, they yielded to provider "expertise". The best remedy (other than having activist consumer representatives) for such acquiescence is to have an HSA staff which itself is willing and has the resources and capability to develop alternative analyses of the need, or lack thereof, for provider proposals and projects. (See #1) In the absence of such support, consumers must do the best they can to prepare themselves for meetings. At a minimum, the consumer representatives should continually ask questions of the advocates of particular projects, as to exactly how they are complying with the criteria set forth in the HSP, AIP, and the certificate of need criteria and whether their arguments are backed with precise quantitative supporting evidence. Consumers should meet among themselves before meetings at which

important decisions will be made to discuss exactly what is in the best interests of consumers and how best to make their arguments. Once again remember that provider groups are organized and amply funded to represent the interests of doctors and hospitals at HSA meetings.

In addition to exerting influence at business meetings, consumers can have an impact by testifying at public hearings. The statute and regulations require public hearings on the proposed Health Systems Plan before an application for full designation is submitted (see #8 below), and on applications for a certificate of need (but only when requested). All of the suggestions discussed above about regular attendance and adequate preparation for meetings also apply to hearings. It is always best to prepare written testimony and to support your assertions with data obtained from the HSA (see #6 below) or by your own devices.

Two important documents on which the HSA is not required by the statute or regulations to hold public hearings are the Annual Implementation Plan and the procedures and criteria for certificate of need review (and later for reviewing proposals for the expenditure of federal funds within the area). The Board or Executive Committee should vote to hold public hearings on the proposed versions of both. They will be perhaps the two most detailed (and therefore most critical) sets of criteria governing the review of certificate of need proposals and proposals for the expenditure of federal funds.

Another approach to disseminating your views to a broader audience is via the press. Find at least one local reporter who covers health or consumer issues and impress upon him or her the significance to the community of the health planning process. Invite the reporter to meetings of your group and keep him or her informed about meetings and hearings. When your group prepares position papers or other written documents expressing the consumer viewpoint for meetings and hearings, be sure that such reporters receive a copy.

6. Adopt a data policy which requires reporting to the HSA of all relevant information by individual providers and guarantees that all information, documents, internal reports, etc., are disseminated or readily available to the public.

The HSA is required by the statute to "make its records and data available, upon request, to the public." The regulations attempt to spell out this requirement in some detail, as follows:

> "(a) Each agency shall adopt a policy for making its records and data available to the public for inspection and copying which shall include a procedure for the submission of requests to the agency by members of the public, the agency's procedure for handling such

requests, and a uniform fee schedule for copying such material which shall be limited to reasonable costs. For purposes of this section, "records and data" includes publications, brochures, pamphlets, punch cards, magnetic tapes, or other documentary materials, regardless of physical form or characteristics, made or received by the agency in connection with the performance of the agency's functions, policies, decisions, procedures, operations, programs, or other activities.

(b) Each agency is required to maintain and make available for public inspection and copying an index of the records and data of the agency and must publish within 3 months of the effective date of its designation agreement, in at least two newspapers of general circulation throughout its health service area, a notice setting forth the policy adopted pursuant to paragraph (a) of this section."

You should urge the HSA to go beyond this policy by publishing a notice of the availability of all proposed and final documents in its newsletter and by waiving the copying fee for those who state they cannot afford to pay. The index should also be published in the newsletter.

Unfortunately, the language of the regulation still leaves many questions unanswered. The definition of "records and data" is drafted in terms of form rather than content, thought it does include "minutes" (presumably of all HSA meetings) and "staff manuals". However, there are other provisions of the statute and regulations which explicitly require publication of or public access to specific documents: the Health Systems Plan (HSP), the Annual Implementation Plan (AIP), procedures and criteria for review of certificate of need proposals (the HSP and the procedures and criteria must be accessible in both proposed and final form), applications for a certificate of need and "all other written materials pertinent to any agency review", a description of the plans and projects recommended to implement the AIP, an annual (or more frequent) report on the status of all pending certificate of need reviews, and a more general annual report which includes, among other items, the HSP, the AIP, financial information about the HSA, and a list of the members of the Board, Executive Committee, and staff. The HSA annual report must be distributed to all libraries, newspapers, and radio and television stations serving the health service area.

The thrust of these provisions in the statute and regulations is that all information and documents in the possession of the HSA must be disclosed to the public. Certainly, consumers should demand that the HSA's disclosure policy explicitly state such a requirement. There are some materials which the HSA will have which are not speci-

fically required to be disclosed by the regulations. For instance, those who are considering facility construction proposals must submit letters of intent to the HSA "at the earliest possible opportunity" and all facilities must submit periodic reports concerning any proposals under development subject to certificate of need review. Also, internal HSA staff reports on the merits of particular certificate of need proposals will be developed in the course of review. Though such reports will undoubtedly be made available to HSA Board members, the data policy must specifically require in writing the disclosure of such documents to the public immediately upon completion.

Whether the HSA will provide any meaningful new information to the public about health care, however, depends on what data it can obtain from existing data sources or what it is able to collect on its own from individual providers or third party payors. The HSA disclosure policy applies only to data it obtains in the first place. One of the most critical weaknesses in PL 93-641 is the lack of legal authority for the HSA to obtain and disclose data which is not now even collected or is collected but not disclosed to the public. If the HSA requests data from a provider, a Professional Standards Review Organization (PSRO), or a third party payor which refuses to provide it, there is nothing the HSA can do, with one exception in the case of providers--it can recommend to the State Agency the denial of a certificate of need to an applicant who fails "to submit to the health systems agency (in such form and manner as the agency shall prescribe and publish) such information as the agency may require concerning the subject of such review". Even here the HSA may probably only ask for data which is necessary to demonstrate compliance with one of the HSA's adopted criteria for certificate of need--another reason why the certificate of need criteria are so critical (see #7 below).

For example, if the HSA adopted a certificate of need criterion relating to quality for facilities wishing to expand or build a satellite facility, (no quality criterion is included among the minimum criteria in the proposed Federal regulations), it could legitimately request data on quality deficiencies from Joint Commission on the Accreditation of Hospitals (JCAH) surveys, and Professional Standards Review Organizations (PSROs). Heretofore, such information has not been available to either health planners or to the public. Whether the HSA can use its certificate of need authority to acquire and publicly disclose data which otherwise would be shielded from public access by Federal statutes is not clear. It can be argued that the provider is not being coerced to release the data, since it does not have to apply for a certificate of need.

However, for the routine, periodic collection of data from all providers, the HSA can not apply pressure by withholding certificate of need approval. It must instead depend on voluntary compliance by providers or on the collection of data by the State Health Plan-

ning and Development Agency. The regulations provide that the State Agency must "require providers of health care doing business in the State to make to the State Agency such statistical and other reports of information related to health and health care as the State Agency finds necessary to the performance of its functions..., and make such reports available to the health systems agencies for the respective health service areas in which such providers are located." The State Agency can always obtain the information it wants by making the reporting of it by the provider a condition of relicensure or perhaps Medicaid reimbursement by the State.

Perhaps the most significant task for HSAs will be the acquisition of this routine statistical data on all health providers in the health service area. There are four categories of data which the HSA is either required to or ought to obtain on an ongoing basis: (1) health resources, and expenditures, (2) quality of health care and structural deficiencies, (3) health status of the population, and (4) environmental and occupational health conditions.

(1) Health resources data concerns the supply of health facilities and manpower--the number and location of hospitals, nursing homes, and outpatient facilities, number of inpatient beds, number of health personnel--and the level of costs, (what it costs the provider to provide a service), charges, (what it costs a patient or his insurer to obtain a service) and expenditures on health in the area. The HSA must also determine the level of utilization of each provider's services--number of outpatient visits, admissions, inpatient days of stay, surgical and other procedures, and amount of drugs prescribed. Third, a population base must be calculated not only for the entire health service area but for each provider's service area. In order to define a service area for each facility, the HSA must have access to a patient information system which collects the residence of the patient (e.g., county or zip code). Such data can be compiled into patient "origin" or "destination" tables which indicate, respectively, where patients come from to a particular hospital and what proportion of the patients from a particular geographic area go to a particular hospital to receive care. The latter is one (albeit imperfect) way of determining the population base to attribute to a particular hospital.

Dividing the population of the area among individual hospitals or physicians in some fashion is a prerequisite to comparing the utilization practices of different providers. In order to get some idea of whether facilities or services are being over- or under-utilized, the HSA must calculate numbers or rates per thousand population of beds, admissions, nursing or hospital patient days, physicians and other personnel, and level of expenditures or assets. Then the rates can be compared with rates for other facilities or other areas. However, even these comparisons are not valid unless the utilization or expenditure figures are "adjusted" or broken down by other variables, especially age, sex, diagnosis, type of surgery, source of payment (including how much "free" care the facility is providing), and whether the admission is emergency or elective. Also, in order to properly compare financial data, one

must know whether the expenditure is a charge to the patient or a cost to the provider (and whether the cost is a capital cost or an operating cost, whether the operating cost is payroll or non-payroll, etc.).

Most health resources and utilization data is either already being collected by existing planning units or state agencies or will be voluntarily reported by providers. The exceptions are data showing number of patients by age, sex, diagnosis, operation, etc., and financial data. The patient data is being collected by Professional Standards Review Organizations (PSROs) but may not be available to HSAs in a facility-specific form (restrictions on access to PSRO data are discussed below). The best sources of financial data are state rate-setting bodies (which exist only in a few states) and third party payors, especially Medicare intermediaries, Blue Cross, Blue Shield, and state Medicaid agencies. Again, HSAs may have difficulty obtaining such data unless the State Agency forces disclosure or the hospital or nursing home consents to disclosure in order to get a certificate of need.

(2) The responsibility for the ongoing, periodic collection of data on quality of care has been given to Professional Standards Review Organizations (PSROs) rather than to HSAs. Consequently, although HSAs can ask a facility for data on quality of care before approving an expansion project, they will not be monitoring quality of care in all area facilities on an ongoing basis. Unless a provider is proposing an expansion project, it has no duty or reason to disclose "sensitive" quality-related data to the HSA. The HSA could request quality data on a facility from the Joint Commission on Accreditation of Hospitals (JCAH) on from the area PSRO. However, JCAH will not now release the results of their accreditation surveys to the public and although the statute and regulations require HSAs to coordinate their activities with PSROs, guidelines on access by the HSA to PSRO data have not yet been developed. HEW Statements on this issue indicate that PSROs will not disclose any information to HSAs which they cannot otherwise disclose to the public. Though regulations on the confidentiality of PSRO data have not yet been published, the policy is likely to restrict public disclosure to aggregate data and data routinely compiled by individual facilities (which includes diagnosis and surgical operation codes for patients). In addition, "medical care evaluation" data, which measures the compliance of physicians and hospitals with quality criteria, will not be disclosed. Neither will any data which identifies individual physicians.

HSAs are required to describe in the Annual Implementation Plan (AIP) what capital expenditure projects (including modernization and renovation) should be undertaken in the area that year and the priority among them. It also needs to know whether a facility proposing expansion has maintained its existing structure in good repair. Thus, it will be important for the HSA to identify those facilities

which need to correct structural deficiencies. Data on the condition of the physical plant of facilities is collected by state authorities responsible for licensure and Medicare and Medicard certification as well as JCAH. As mentioned above, however, because information from inspections of hospitals and nursing homes is usually not disclosed to the public, the HSA may have difficulty obtaining it except where a facility is goaded into consenting to its release in order to get certificate of need approval.

(3) HSAs will also be required to collect and analyze data on the health status of the population of the area--mortality and morbidity rates by cause of death and illness, perhaps disability days and work days lost due to illness, and longevity. In the long term the HSA should be analyzing changes in the health status of the population and attempting to direct its efforts toward those activities which have the most favorable impact.

(4) Finally, the statute requires HSAs to "assemble and analyze data concerning the environmental and occupational exposure factors affecting immediate and long-term health conditions." What is included in this category and how the HSA will be able to use such data is almost completely undefined. None of the other statutory HSA functions have any direct relationship to environmental or occupational health.

One of the greatest obstacles to dealing with occupational health problems is the lack of data about workers' exposure to hazardous chemicals in workplaces. The HSA can request from area employers information about their use of such chemicals, particularly vinyl chloride, asbestos and the other carcinogens regulated by the Occupational Safety and Health Administration (OSHA). The HSA can also determine what kind of medical records are maintained by employers on present and past employees. The problem is that the HSA can impose no penalty if the employer either doesn't collect such data or refuses to disclose it. HSAs ought to initiate and maintain contact with local union leaders to inform them about HSA occupational health activities and to learn about occupational health problems of union members. The disclosure of data on occupational health hazards to the HSA, the union, and the public can be made a collective bargaining issue. The HSA can also provide public support to the unions in their efforts to get employers to eliminate health hazards from the workplace. The HSA should encourage health facilities to add to the standard medical history of each patient a section on work history and occupational exposure to chemical substances.

The important issues from the consumer perspective are to make sure the HSA has a written data policy which guarantees public access to all data or material in its possession and to push the HSA to collect all data relevant to assessing the necessity, costs, efficiency, and impact on quality of delivery and health status of all its activities and decisions.

7. Be actively involved from the earliest stages in the initial development of the Health Systems Plan (HSP), the Annual Implementation Plan (AIP), and the procedures and criteria for certificate of need review. NO proposals for new inpatient hospital construction or major capital equipment should be granted a certificate of need until these three documents are completed and approved.

One of the central weaknesses of previous health planning efforts was that planning agencies attempted to perform review of proposals for construction and capital expenditures without any specific criteria or a written description of what the health care delivery system in the area ought to look like. When consumers and planners oppose providers concerning the approval of a particular project, the providers are likely to prevail unless consumers have detailed, predetermined, objective, written criteria and a plan against which the provider proposal has to be measured. Such a plan shifts the burden to the provider for developing the quantitative data necessary to demonstrate compliance with the criteria. A good plan is important not only for justifying a consumer-oriented decision to the State Agency and to the public but also for encouraging activities to improve the delivery system, discouraging activities and projects which are ill-advised and unnecessary, and, not to be overlooked, forcing the providers to report data about their activities which otherwise would remain secret.

The HSP, AIP, and the initial set of procedures and criteria have all been discussed above in terms of access to information and requirements for public hearings. With the exception of developing an adequate data system (which is really part of the process of developing a good Health Systems Plan), the development of these three documents should be the primary focus of the HSA during its conditional phase. Details about the nature, location, and use of hospitals and other facilities contained in the plans are so essential to adequate health planning that no project review should even be entertained by the HSA until all three are completed and approved. The statute and regulations require that the plans, procedures, and criteria be completed before the HSA can be fully designated. The law implies, but never explicitly states, that review of individual certificate of need applications cannot begin until the plans and criteria are adopted. One of the first actions taken by your group should be to urge the HSA Board to agree in writing to a moratorium on all certificate of need review until the HSP, AIP, and certificate of need procedures and criteria are adopted.

Even if the HSA places a moratorium on certificate of need review under the PL 93-641 framework, however, planning reviews will still be taking place under existing planning mechanisms. All but two states (Missouri and West Virginia) now have either certificate of need agencies, an "1122" agreement with HEW (which requires planning approval for Medicare and Medicaid reimbursement of capital expenditure costs), or both. Under these programs local review in most states has been done by CHP "B" agencies. After CHP agencies

are terminated or merged into HSAs, the HSAs will in most areas perform local review under the existing programs during the interim period before the State Health Planning and Development Agencies (SHPDAs) are fully operational and in compliance with Federal requirements (which allow the SHPDAs to administer an 1122 program in addition to a certificate of need program if they choose). In short, in order for a moratorium to have any impact, it must apply to HSA reviews under the current state framework even if they are not labeled as 93-641 reviews.

As suggested above, the two kinds of capital expenditures for which a pre-plan moratorium seems most appropriate are construction which increases the number of hospital beds and the purchase of major capital equipment (such as CAT scanners). Depending on conditions in your area, other types of projects might be included. Given the need in most areas for better primary and ambulatory care facilities, a moratorium on such proposals may not be appropriate. However, the review of any proposal should be based on written criteria and, before completion of the HSP, should only be done in exceptional cases.

The HSA must conduct a public hearing on the Health Systems Plan (HSP) before it can be adopted by the Board. The regulations require the HSA to publish at least 30 days before the hearing newspaper notice of the time and place of the hearing and the place where members of the public can read and comment on the proposed HSP. The regulations do not require the HSA to disseminate the draft HSP to anyone or to in any other way publicize the HSP or educate the public about what is in it. Interested persons are to be given an opportunity to submit their views orally and in writing. HEW's draft guidelines for developing the HSP require the HSA to "maintain a summary of comments and reactions to the HSP for those interested in viewing them." After the HSP has been adopted, the HSA is required to distribute copies to all public libraries in the health service area and to publish newspaper notice that the HSP has been adopted and the place where it can be read and copied.

There is no requirement in the regulations for a public hearing or even public notice prior to establishment of the Annual Implementation Plan (AIP). The draft guidelines do require the HSA to conduct "annual public review" of the AIP, however. The same requirements for dissemination to libraries and public notice after the plan has been adopted apply to the AIP as to the HSP.

The HSA must go far beyond these minimum requirements for both the HSP and the AIP if there is to be any real opportunity for public involvement in their formulation. The HSA should adopt a written plan for community involvement in the development of the plans which includes notice to everyone on the newsletter mailing list mentioned in #4 above, publicity in all subareas through contact with community groups and radio and television announcements (perhaps 90 to 120 days before the hearings), mailing a copy of the draft HSP and AIP to anyone who requests it, public hearings in all subareas,

and solicitation of oral and written comments which must be considered and rejection of which must be justified by the HSA before the plan is adopted.

Both in past health planning efforts and thus far in the implementation of PL 93-641, HEW has largely failed to specify what ought to be in a health plan and planners have not often succeeded in reducing meaningful and detailed objectives concerning the health delivery system to writing. In the CHP program, health planning agencies either didn't complete a plan, or if they did, it was so vague and general as to be of little assistance in the review of individual proposals. What little has been written by HEW since PL 93-641 in the regulations and guidelines about the content of HSPs and AIPs is both too broad and too superficial. On one hand, HEW suggests that the HSP should include goals relating, for example, to attainable levels of mortality and morbidity, with which no one would disagree but which HSAs have only the most marginal ability to influence. HSAs have only three types of authority, none of them final or binding: they can recommend to the State Agency denial or approval of a certificate of need for facility construction or capital expenditures; they can recommend to the State Agency which facilities and services should be publicly identified as being inappropriately utilized; and they can recommend to HEW that proposals for some types of federal funding be denied. On the other hand, HEW fails to require or provide any details about quantitative objectives for such projects as facility construction (e.g., hospital bed ceilings by area) which the HSA can do something about.

Whatever other general language is included in the HSP, it ought to at least specify details about the quantity, location, and type of health facilities in the area, if it is expected to have any real impact on the health planning process. At a minimum, the HSP must set bed ceilings by category of inpatient facility (general medical-surgical, obstetrics, pediatrics, psychiatric, skilled nursing, intermediate care, etc.) and by area or subarea. The ceilings should be based on the current population of the area. For example, "The Center City metropolitan area needs no more than 1500 general medical-surgical hospital beds to serve its 400,000 residents" or "The Center City metropolitan area needs no more than 350 psychiatric hospital beds to serve its 400,000 residents". If the population changes, the bed ceiling should be adjusted to maintain the same ratio of beds to population.

If there is an excess in any category, the amount of the excess must be identified (which of course presupposes that the HSA has done an inventory of how many beds there are in each category). The excess beds should also be broken down by subareas. If there are deficiencies in any category, the amount of the deficit must also be identified. The HSP should identify the need for and present location of major types of equipment and special services such as intensive care units and computerized axial tomography (CAT) x-ray scanners. One section of the plan should inventory the need for, and

present location and adequacy of, outpatient, emergency, and other primary and ambulatory care facilities and services, especially in medically underserved and poverty areas. Finally, a blue-print for the optimal distribution and location of all of the above categories of facilities and services should be included.

Some CHP "B" agencies have completed very comprehensive plans for purposes of local planning and certificate of need review which incorporate many if not all of the suggestions made here, including identification of excess beds. Such plans will and should be used for guidance. These documents are often quite impressive in terms of inventorying existing facilities and discussing problems and priorities. However, usually they stop short of a critical assessment of existing patterns of utilization. Bed need, when it is calculated at all, is based on the Hill-Burton formula which merely assumes 85% as an appropriate occupancy rate and considers only existing facility utilization and changes in population. Also, financial data is almost always missing. Going one step further to calculate and compare rates of utilization and amount of resources per thousand population as suggested under #6 above would be a marked improvement. But HSAs must ultimately face and answer such questions as whether existing rates of surgery and hospitalization and the number of hospital beds and level of capital assets relative to population are too high. If so, the HSA must detail in its HSP and AIP what should be done to reduce or change the allocation of health resources and how to do it.

The Annual Implementation Plan (AIP) should start with the objectives, excesses, and deficits described in the HSP. It must list in specific detail which facilities and services should be built, purchased, renovated, converted to other health care uses, or closed down, and where, in the next 12 month period. The projects to be undertaken should be listed in order of priority. This priority list will provide the basis for the State Medical Facilities Plan, which governs the distribution of federal funds made available to states under the Hill-Burton program (since PL 93-641, Title XVI of the Public Health Service Act) for the construction and modernization of health facilities.

Actually, under the statute and regulations the priority list would be a separate document based on, but not included in, the AIP. It is essential for consumers to make certain that the priority list of capital expenditure projects is an integral part of at least the AIP if not also the HSP. Otherwise, the HSA staff would be able to develop the list without being subject to the public scrutiny and review required for the HSP and AIP. Also, both plans must be revised annually. Unless such a periodically revised list of specific projects is determined in advance with full public participation, the HSA Board will have to continually interpret the more general language of the HSP as it performs certificate of need review and the provider applicants in each case will usually be able to argue that their project is consistent with the vague goals of the HSP. Having

a detailed list of specific projects makes it much easier for the HSA to deny any project which is not included at all or is given low priority.

The HSA must also adopt, during the conditional period and before it may perform project review under PL 93-641, a set of procedures and criteria for certificate of need review. The statute and regulations require the HSA to provide newspaper notice that such procedures and criteria are being proposed and where they are available for inspection and copying, and to accept written comments. After the procedures and criteria have been adopted, the HSA must provide copies to any person on request. There is no requirement that a public hearing be held or that the HSA consider or give reasons for rejection of the written comments.

The effectiveness of certificate of need review by HSAs--from the consumer perspective--will depend very heavily on the degree of public involvement required by these procedures and the completeness and precision of the review criteria. In light of the importance of the procedures and criteria, it is imperative that consumers be fully involved in their development. First, notice of the proposed procedures and criteria should be included in the HSA newsletter as well as in the newspaper. Second, copies of the draft procedures and criteria should be sent to all consumer groups and to any other person who requests them. Third, the HSA should hold a public hearing at which all oral comments are transcribed. All comments must be taken into consideration before the HSA Board adopts the procedures and criteria and reasons must be given in writing for the rejection of suggestions for changes. Fourth, copies of the adopted procedures and criteria should be sent to everyone on the newsletter mailing list.

The proposed regulations specify minimum procedural requirements which all HSAs must meet. The procedures include notification by newspaper publication of the beginning of each review, completion of HSA review and recommendations to the State Agency within 60 days, a public hearing at which any person has an opportunity to present testimony (but only if requested within 30 days of notification), and written findings stating the basis for any decision, which must be made available to the public on request. The weakness of this approach is that it places the burden for initiating a public hearing outside the HSA. In order to encourage community involvement in certificate of need review, the HSA should routinely hold a public hearing on each application. It should include in each of its periodic newsletters a list and brief description of all certificate of need applications which have been received, and the time and place of the public hearing. The review cycle would begin on the date of the newsletter which gives notice that the application has been received. (The HSA would still be required to publish newspaper notice). The date of the public hearing should be at least 30 days after the date of notification in order to afford consumer groups adequate time to prepare their oral and written testimony. Oral

comments should be transcribed and all comments, written or oral, should be taken into consideration by the HSA in making its findings. Reasons should be given for the rejection of each comment in the HSA's written findings.

The proposed regulations list a minimum set of criteria which must be met by all certificate of need applications. The criteria include consistency with the HSP and AIP, public need for the proposed service, whether there are better alternative approaches to providing the proposed service, whether the applicant can secure the financing and the personnel to actually provide the service, and whether the proposed service will be appropriately coordinated with other related facilities and services. There are also criteria suggesting special consideration for tertiary care centers, health maintenance organizations, and research projects. Finally, in the case of construction projects, there must be consideration of both the costs of construction and the impact of the project on future operating costs.

There are at least three ways in which the proposed criteria should be altered or expanded. First, the cost criteria which apply to construction proposals should be applied to all capital expenditures over $50,000 and should include consideration of projected savings in operating costs, and charges or changes in charges which will result from the proposed capital expenditure. Second, there ought to be an explicit criterion regarding the health benefits to patients which are expected or likely to accrue from the proposed project, i.e., the evidence that the project will serve to improve or maintain health, whether it will reduce risks to patients, save lives, avoid sickness, or lead to more effective treatment. Third, it would seem to be more appropriate and consistent with the avowed purposes of PL 93-641 to give special consideration to the medically underserved rather than to teaching hospitals (which do get special attention under the proposed criteria). All projects should be reviewed in light of the current deficiencies in primary care in inner city poverty areas and remote rural areas.

The proposed regulations also include certain required findings for the granting of a certificate of need for new inpatient facilities. These include the findings that there is no cheaper alternative to inpatient construction, that existing inpatient facilities are being appropriately and efficiently utilized, that modernization or sharing arrangements alone would not be adequate, and that patients will have difficulty obtaining inpatient services if the project is not undertaken. These criteria are appropriate but do not provide enough detail. First, no one who owns existing facilities should be allowed to expand unless he or she can show that the facilities he or she owns are being utilized with maximum efficiency (by documenting a pre-admission review system which is effective in preventing unnecessary hospitalization, for example), that the facilities are providing high quality care (if they are not, expenditures should be made on correcting quality deficiencies rather than expansion) and that the facilities are meeting the requirements of the Hill-Burton law for

providing free care and community service. Second, no inpatient construction should be allowed if the area is already at or above the bed ceiling specified in the HSP or AIP or if the apparent need for new beds is actually a result of inappropriate utilization of existing hospitals in the area or if there are a substantial number of unoccupied beds in other existing hospitals.

Finally, there should be similar required findings for other major categories of capital expenditures such as outpatient facilities and major capital equipment such as computerized axial tomography (CAT) scanners. All should involve strict scrutiny of actual health benefits which will accrue to patients and actual costs, both acquisition and operating or maintenance costs.

At this point, the health planning authorities and activities required by PL 93-641 at the state level should be mentioned. The State Health Planning and Development Agency (SHPDA), has final authority to grant or deny a certificate of need. The Statewide Health Coordinating Council (SHCC) advises the SHPDA and must approve the State Health Plan (SHP), which is largely made up of HSPs from health service areas within the state. The SHPDAs, most of which have now been designated, must also adopt procedures and criteria for certificate of need review at the state level.

The Health Research Group is developing a model state certificate of need statute to comply with the criteria of PL 93-641 and also include provisions designed to strengthen the accountability of the State Agency to consumers. Copies of the model statute can be obtained for $2.00 by writing to the Health Research Group, Suite 708, 2000 P St. N.W., Washington, D.C. 20036. The statute will be accompanied by commentary about how consumers can become involved in health planning at the state level. One important question which will be answered by state certificate of need laws is what kinds of proposed services are subject to review. The minimum coverage required by PL 93-641 includes, for example, only capital expenditures in excess of $150,000 and does not include expenditures by physicians on equipment (such as $500,000 CAT scanners) for their private offices. The latter issue is particularly controversial. Physicians' offices were excluded from coverage under the proposed regulations because of pressure from organized medicine. Consumers must fight to close this loophole by including physicians' offices under their state certificate of need law, which can provide for broader coverage than the Federal regulations.

8. <u>During the HSA's period of conditional designation, be sure to document and complain about--informally, in written comments, and at public hearings--all instances of unresponsiveness to consumer interests. Copies of your complaints should be sent to the HSA Board, the Governor, the Statewide Health Coordinating Council, your Congressperson(s) and the Health Research Group.</u>

All HSAs are now conditionally designated. Their conditional

status will continue for either one year or two years from the date of the conditional designation. In order to be fully designated, the HSA must submit another application to both the Governor and the regional office of HEW. In addition to demonstrating that the HSA is capable of performing all the required statutory functions, the application must include

> A detailed description of the manner in which the community has been involved in the submission of the application including evidence that the applicant has provided at a minimum an opportunity for members of the public to express their views on the qualifications, proposed governing body composition, and proposed application of the applicant both in writing and at a public meeting sponsored by the applicant entity. Notice of the time, place and purpose of such meeting shall be given to members of the public through publication of a notice in at least two newspapers of general circulation throughout the health service area at least two weeks prior to such meeting. Such meeting must be held at least 30 days prior to the submission of the application to the Secretary. Such notice shall also provide that a statement of the qualifications and proposed governing body composition of the applicant and a copy of the proposed application will be available for public inspection and copying at a specified address, and shall invite written comments thereon by members of the public. A summary of the comments made at the public meeting and copies of any written comments shall be appended to the application.

Of course, your group should make sure that hearings are held in all subareas, that they are publicized through the newsletter, and that you obtain a copy of the proposed application.

The Governor will be given 30 days for review and comment after the submission of the application--the same procedure as for the conditional application. If the HSA is not conducting its business openly and/or is not being responsive to the best interests of consumers in its development of the Health Systems Plan, the Annual Implementation Plan, and procedures and criteria and in its certificate of need review decisions, consumer groups will have another opportunity to prevent them from being fully designated or at least influencing HEW to condition its full designation on specific improvements in the procedures of performance of the HSA. This time around the HSA will have something of a track record to take into consideration. Consumer groups which supported losing applicants for conditional designation (or which themselves were the losing

applicants) should have a special interest in closely monitoring the sensitivity of the conditional HSA to consumer interests.

Important points to remember are (1) document everything you want to complain about immediately and in writing, (2) send a copy of such documentation immediately (do not wait until the HSA starts to develop its application for full designation) to the governing board of the HSA, the regional office of HEW, the Governor's office, the Statewide Health Coordinating Council, your Congressperson(s), and the Health Research Group, and (3) compile all such documentation and include it with your oral and written comments made at the public hearing (which must be attached to the application for full designation).

All of the above-mentioned people and groups should be kept informed about the performance of the HSA because all are involved directly or indirectly in the decision by HEW on full designation. HEW is required to consult the Governor and the Statewide Health Coordinating Council, and members of Congress will not hesitate to try to informally influence the decision. The Health Research Group can make use of such complaints by giving them publicity in the press and by confronting the HEW officials in Washington who have responsibility for implementing the health planning law.

Two final caveats are in order. First, the discussion about certificate of need criteria and procedures is based on proposed Federal regulations. The final regulations, which are due to be published sometime before the end of the year, will undoubtedly contain changes (HEW received 3,000 comments on the proposed regulations). Be sure to obtain a copy of the final regulations and have an HSA staff person explain any changes that have been made. Second, and perhaps more ominous, the legislative authority for PL 93-641 expires on June 30, 1977. Congressional committees will begin holding hearings on amendments to the law early in 1977. Organized medicine will be working for repeal or at least weakening of the law. Governors and local politicians will ask Congress to turn health planning back to the states or at least give state and local governments more control. In short, various vested political interests will be trying to amend the law in ways which could be detrimental to consumer interests. Thus, consumers must demonstrate over the next several months that health planning controlled by consumers can work.

Important Tasks Required of the Health Systems Agency (HSA), the State Health Planning and Development Agency (SHPDA), and the Statewide Health Coordinating Council (SHCC) during the Conditional Designation Period.

HSA	SHPDA	SHCC
Must be completed before full designation:		
Collect Data		Formation
Adopt Health Systems Plan (HSP)	Develop State Health Plan (SHP)	Approve SHP
Adopt Annual Implementation Plan (AIP)	Develop State Medical Facilities Plan (SMFP)	Approve SMFP
	(State Legislature Must Pass/Amend State Certificate of Need Statute to Comply with PL 93-641)	
Adopt Procedures and Criteria for Certificate of Need Review	Adopt Procedures and Criteria for Certificate of Need Review	
Not Required Before Full Designation:		
Certificate of Need Review	Certificate of Need Review	
Periodic "Appropriateness" Review*	Periodic "Appropriateness" Review	
Federal Grant Review*		Review Applications by State for Federal Funds
*(Neither can be performed until after the first year and after adoption of the HSP and AIP)		

A GLOSSARY--FOR EATING THE ALPHABET SOUP OF HEALTH PLANNING

Following is a slightly revised and expanded version of a glossary published in the first CHAN newsletter:

Health planners seem to speak a foreign language. The language abounds with letters, sections of laws, designated this and that--in short, all the ingredients for confusion to the uninitiated. To slip into verbal shorthand with colleagues is understandable. It saves time. However, when non-experts involve themselves--and that is the idea for health planning--jargon is intimidating and counter-productive. It wastes time.

Because subscribers to CHAN range from professional health planners to interested consumers, Health Research Group includes a brief glossary to commonly used terms in health planning. Many of the terms appear in CHAN. Others are bandied about at public meetings. Consumers will find themselves on much better footing if they know some of the jargon. Health planners might glance through the glossary too. Not with an eye towards information gathering for themselves, but rather with an eye towards reacquainting themselves with how much others have to master.

LAWS & PROGRAMS

Hill-Burton: The first federal health planning effort, the Hospital Survey and Construction Act of 1946 (42 U.S.C.§291 et. seq.), set up a network of State agencies to assess the need for health facilities. The agencies were responsible for developing plans to construct those facilities and for funding the construction. To the good, the Hill-Burton program built hospitals in long underserved areas. To the bad, the Hill-Burton program fixated on acute care beds with a disinterest in an integrated medical system which offers out-patient care where appropriate.[1]

CHP: The Comprehensive Health Planning and Public Health Services Amendments of 1966 (P.L. 89-749; codified at 42 U.S.C.§291 et. seq.), grafted onto the already extant voluntary health planning structure. State CHP "A" agencies and local CHP "B" agencies were to monitor the construction of health facilities and furnish an arena for providers, government, and consumers to discuss health planning. A last minute insertion in the law which prohibited CHP's from interfering with existing patterns of private practice of medicine[2] assured that the teeth of the legislation were blunted.

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[1] Barry Ensminger, The $8 Billion Hospital Bed Overrun, (Health Research Group, 1975), 47ff.

[2] Ibid., 50ff.

RMP: The Heart Disease, Cancer, and Stroke Amendments of 1965 (P.L. 89-239; codified at 42 U.S.C.§246 et. seq.) authorized the creation of Regional Medical Programs to coordinate medical research and disseminate the results of research throughout the health care system. DHEW designated regional agencies which received federal funds to accomplish these functions. Subsequently these designated RMPs received more funds and expanded their jurisdiction to include data exchange and construction projects among other things. The RMPs got into the health planning process to the tune of $1 billion.

Section 1122: Section 1122 of the Social Security Act (42 U.S.C. §1320a-1, 42 C.F.R.§100.101 et. seq.) became effective in January, 1973. Under section 1122 DHEW pays the administrative costs to submit proposals for additional construction to a review process. In order to be approved, they must fulfill a "public need." Conditioned on the successful passage through the review process are reimbursement of Medicaid, Medicare, and Title V. The CHP agencies were to act as reviewers at a local level. 38 states participate in the Section 1122 program.

Certificate of Need: Certificate of Need (C/N) laws vary in each of the 30 states which have enacted legislation with respect to structure and authority. The main thrust is to insist that "public need" be demonstrated before expansion of health facilities or services can take place. CHP "B" agencies usually perform local review under C/N.

PL 93-641: The National Health Planning and Resources Development Act (codified 42 U.S.C.§300k-1 et. seq.) was enacted on January 4, 1975. It represents the third legislative try to make sense out of health planning. New health planning agencies will replace CHPs, Hill-Burton, and RMPs. These health planning agencies will have bigger staffs and therefore have the opportunity to depend less on industry. PL 93-641 mandates Certificate of Need legislation in every state, in addition to continuing to fund Section 1122. Most important, the consumer is written into PL 93-641. Consumer majorities are required at the local level and can dominate 60% of the areawide board membership. However, in order to be effective, consumers must become knowledgeable about the law and the health needs of their areas.

PL 93-641 contains many new terms. Here are a few useful ones:

HSA: Health Systems Agencies are the planning agencies established to review construction proposals. The role of the HSA includes (a) gathering and analyzing data from objective sources such as statistics generated from the health care delivery system and from subjective data, such as people's opinions based on their health needs and experiences; (b) formulating health plans and criteria for judging "need" based on community wants: (c) educating the community

about the long-range implications of their local health plan; (d) start slowing the increase of health care costs by scrutinizing new investment to see whether it fits into the local plan. The staffs of HSAs will consist of 5 to 25 people. The majority of the governing board of the HSA must be consumers.

HSA: Health Service Area--HSA can also stand for the area covered by a Health Systems Agency.

SHPDAs: State Health Planning and Development Agencies are the state-level equivalents of HSAs. The SHPDAs are supposed to assemble the health plans of HSAs within the state to formulate an integrated state plan. They also administer and have final decision-making authority in Section 1122 and Certificate of Need programs.

SHCC: Statewide Health Coordinating Councils consist of at least 16 members, appointed by the governor, of whom 60% represent HSAs. At least 1/2 must be consumers. The Councils approve State Health Plans, review budgets for HSAs, and advise the state agencies.

HSP: Health Systems Plans are blue prints for community health needs made up by HSAs.

AIP: Annual Implementation Plans--the nuts and bolts as to what will happen in an area during a one-year period.

PSRO: Professional Standards Review Organization, a Federal program still in its early stages. PSROs are supposed to monitor the quality of medical care by audits of individual practitioners and services. PSROs are supposed to make some of their data available to HSAs.

SAC: Subarea Advisory Councils--HSAs may, but are not required to, establish SACs at the local level to advise them on their functions. SACs provide an opportunity for more consumers to be directly involved in HSA activities. SACs are also required to have a consumer majority.

SHP: State Health Plans will be composed of HSPs for health service areas within the state. They will be prepared by the SHPDA and must be approved by the SHCC.

SMFP: State Medical Facilities Plans describe which health facilities need further construction or modernization. SMFPs are prepared by the SHPDA and approved by the SHCC. They are a prerequisite to the state's receiving Hill-Burton money.

GENERAL TERMS

Rate Review or Rate Setting: Rate Review translates into how much money hospitals and other providers of health care receive from insurance companies, federal and state programs, such as Medicaid, and individuals. In this system institutions project financial needs in advance and set charges (rates) accordingly. An agency reviews these rates, and the institutions must operate within the budget or go into the red.

Capital Expenditures & Services Controls (CES): The CES Controls means examining the supply of facilities and services with the intention of balancing off need against the expense of expansion and modernization. The goal of CES controls is to discourage the creation of facilities over and above community needs. Certificate of Need is an example of direct control whereas Section 1122 is an example of indirect control.

Mr. FLORIO. Dr. Carter?

Mr. CARTER. Thank you, Mr. Florio.

I do not have many questions. I heard one statement there and I wonder if I heard it correctly, that insurers are really a bankers' organization? Is that correct?

Dr. WOLFE. No, I said that they functionally have been serving in a capacity which I think can be described as a banking operation for providers. They have only barely scratched the surface of the potential they have for controlling health care costs. They have allowed health insurance premiums to increase in direct proportion to whatever expenditure, needed or unneeded, has been put out by the providers.

So what I am saying is that functionally it is unreal to disassociate them from providers and therefore, allow them, as opposed to providers, to become financial supporters of HSA's.

Mr. CARTER. Along that line——

Dr. WOLFE. Some of them are also bankers.

Mr. CARTER [continuing]. I notice that you are advocating much tighter governmental controls in every way, is that not correct?

Dr. WOLFE. In health planning, you mean?

Mr. CARTER. All the way through, it seems to me, all through your statement here you have advocated much stricter control by the Federal Government.

Dr. WOLFE. Well, by the Federal Government through the HSA's. I think the idea of passing Public Law 93–641 was an admission that the previous Federal authority over health planning was too weak, so that if the purpose of Public Law 93–641 was to strengthen the authority, we are suggesting amendments that would continue to go in that direction. The evidence thus far is that it has not worked.

Mr. CARTER. Now, since you do not think that the insurers—and I would refer specifically to Blue Cross and Blue Shield—do not think that they have done their duty as they should, why is it that the cost of administering their program is so much less than it is for the Government's cost of administering medicaid?

Dr. WOLFE. Well, I think you are referring to some comparisons that came out about 1½ years ago that——

Mr. CARTER. No, I am referring to knowledge I gathered over the years.

Dr. WOLFE. Okay, well——

Mr. CARTER. It is commonly accepted.

Dr. WOLFE. Well, I do not accept it. I think that in a number of the comparisons I have seen, what has been included for the Blue Cross-Blue Shield as opposed to the medicaid are really different packages of administrative costs. I have not seen any data that looks at exactly the same jobs done by medicaid and Blue Cross and Blue Shield that says that Blue Cross and Blue Shield have lower costs. But that is really a different issue that I am speaking to. I am speaking——

Mr. CARTER. Well, since you brought that up, what percentage of dollars spent by Blue Cross and Blue Shield is for administration?

Dr. WOLFE. I believe the most recent figures I have seen are somewhere between 5 and 10 percent.

Mr. CARTER. About 8 percent.

And for administering the medicaid program by the Federal Government, what percentage, per dollar, is that?

Dr. WOLFE. I do not know.

Mr. CARTER. You do not know?

Dr. WOLFE. I think it might be something like 20 percent, but——

Mr. CARTER. 20 percent.

All right, that there, that is a crucial point to me. 20 percent for administering this program——

Dr. WOLFE. But the job——

Mr. CARTER [continuing]. When a private group, or private, nonprofit group does it for 8 percent——

Dr. WOLFE. But they are not——

Mr. CARTER. Thank you very kindly.

Dr. WOLFE. But they are not doing the same job, as I pointed out. You are comparing apples with oranges.

Mr. CARTER. No, I am not either, absolutely not.

Dr. WOLFE. Lemons with oranges.

Mr. CARTER. Absolutely not. You are just coming out for more of the same.

If we followed what you said, we would have a medicaid jungle in this country, I am afraid. Every time we involve the Federal Government more and more, it gets worse and worse. until finally we—I do not know. I just feel that we should leave it as much as we can to private enterprise, so long as it performs within the bounds of reason.

Mr. FLORIO. Mr. Waxman?

Mr. WAXMAN. Thank you, Dr. Wolfe, for your testimony. I have just a few questions.

On point No. 5, you recommend a certificate-of-need requirement, a loophole that you would like to see plugged up. You say HEW should also be given the authority to require coverage of equipment purchases which are less than $150,000. It would have a major effect on operating costs such as the so-called low-cost CAT scanners now being monitored, and fetal monitors.

I am wondering if you would set a lower limit, or do you want all purchases reviewed? Where would you have us draw the line?

Mr. BOGUE. Well, this proposal has actually been previously considered by the subcommittee, I believe during the markup of the cost containment bill last year. There was a provision that was, at one point, in a version of the bill that you were considering; what it would do is give to the Secretary of HEW the discretion, according to certain narrowly defined criteria, to say that a particular piece of equipment, because of its major impact and operating costs, even though its initial capital costs might be lower than the threshhold, lower than $150,000, should be covered by all state certificate of need programs.

I think fetal monitors is a good example of that, and the other recent example, as Dr. Wolfe has already pointed out, is the CAT scanner industry, in an attempt, quite clearly, to get around the capital expenditure review requirements and certificate-of-need programs, have developed a CAT scanner that sells for less than $100,000.

And even though it sells for less than $100,000 it can generate much

more than that annually in operating costs despite the lower, initial capital cost.

So we think that loophole needs to be covered, and what we are really concerned about are operating costs that are generated by this capital equipment.

Dr. WOLFE. In other words, what we are saying is that automatically all purchases above a certain threshhold should be reviewed, but that below the threshold there would be discretion that takes into account the impact of the purchase. Even if the purchase is only $50,000, or in this case $90,000 or $80,000, there may be something about it that reveals much more expenditure on the horizon, even though the item itself does not cost that much.

Mr. BOGUE. I do not think we would be opposed to a requirement that said there would have to be some minimal amount of operating costs projected from that piece of equipment, rather than leaving it wide open, so that the Secretary could designate anything, even if it had relatively low cost.

It would only be those pieces of equipment that had a major impact.

Dr. WOLFE. Six of these low-cost CAT scanners, for example, were ordered in the last couple of months in the Chicago area. Though, technically, their cost fell underneath the ceiling, on a voluntary basis they have been reviewed. I do not think, however, that we can count on such voluntary processes to occur in other parts of the country.

Mr. WAXMAN. Since the law envisions that HSA's would be dominated by consumers, would you then end up duplicating staff by having a separate staff for those who are the consumers on the board? Don't you think the problem is that HSA's are not dominated by consumers, and we should change the law to make sure that the intent of Congress is carried out?

Dr. WOLFE. Technically, the board composition makes it appear that they are, but again, there is a difference between nominal consumerism where you have a certain percentage, and functional consumerism where the consumers are informed enough.

Dr. Carter's idea of letting the free enterprise system operate is a good one if all the sides are able to do battle and really make it function properly. But I think Dr. Carter is as aware, or more aware than I that the information that is really needed down at the local level, not in Washington. In health planning area Washington needs to serve a facilitating role to allow those folks back home to work out their problems as best as possible.

Really, what we are saying here is that most consumers on these boards do not have enough information to answer the often impressive, although sometimes misleading, presentations made by providers for the need to do this and that. The more they are informed by an independent staff, that gives them as much of a handle on things as the providers already have through their trade associations, better planning is going to go on locally, which is where planning has to occur.

Mr. WAXMAN. Implicit in your statement is the assumption that the staff for an HSA is provider-dominated——

Dr. WOLFE. It often is.

Mr. WAXMAN. And therefore, the only way to balance that is to give the consumers, whom you, perhaps, consider to be just nominal consumers, a separate staff.

Dr. WOLFE. That is correct.

Mr. WAXMAN. Now, if those consumers are just nominal consumers, are you not then going to have two sets of staff that are going to end up doing the same thing, making the same recommendations?

Dr. WOLFE. Perhaps, in a very few HSA's, you will. But I think that more likely what you will do is have a backup staff for consumers that will allow them to participate much more effectively in fending off these never-ending series of proposals made by providers.

I think there are a few places where that might be a problem, but unfortunately, not too many.

Mr. WAXMAN. Thank you.

Thank you, Mr. Chairman.

Mr. FLORIO. Gentlemen, I would just like to make an observation with regards to your comments to Dr. Carter about the role of the carriers, that is, the private carriers and the nonprofit carriers. I am not quite as pessimistic as you appear to be, because we have seen some of the carriers start to utilize the reimbursement mechanism in a more responsible way, saying that they are not going to reimburse for certain activities that they regard as not being as cost containment oriented as they should be.

So I really think what we should be doing is trying to encourage that, out of their self-interest as well as the total public interest. I am not sure exactly how to go about doing that, but I think it is a trend that I am starting to see in a number of areas that is healthy, and we should be doing everything possible to encourage that.

Dr. WOLFE. I would agree. I am not saying that the few examples that you and I are both aware of, where the insurance industry has begun to put the lid on things, should not continue.

Rather I do not think it is very healthy from the standpoint of insurors providing financial support for the HSA's.

Mr. FLORIO. Let me just conclude with a question that I have asked everyone we have had here in the last 2 days, do you think that the requirements contained in this bill for having 25 percent mandated prospectively elected officials as part of the board is desirable?

Mr. BOGUE. I think, if we had to choose between the present framework and one in which there was a 25-percent requirement for local officials, that I believe that there is some advantage in having those local officials there in terms of accountability.

I think that you cannot generalize about local officials, though. It depends an awful lot on what the local political situation is and whether or not those officials are pro-consumer, pro-provider, neutral, effective, or ineffective. It depends an awful lot on who the individuals are.

What we actually did, in an amendment that we proposed earlier to the staff, was to say that the requirement for consumer representation should be increased to 65 percent and the requirement for provider representation should be decreased somewhat to 35 percent. The local

officials should be required to be represented, but they would have to be identified as either providers or consumers.

Local officials I think we would favor to the extent that they are active and they are, in fact, accountable.

Mr. FLORIO. Gentlemen, thank you very much. We appreciate your testimony.

I am sorry. Dr. Carter has one more question.

Mr. CARTER. I was interested in your colloquy concerning CAT scanners. In Louisville, Ky., we are fortunate that St. Anselm and the Baptist Hospital have gone together and have one that they use that way, and I would always like to compliment them on their cooperation and their saving in this way.

But, as a legal question, if a private practitioner who caters to nonfederally funded patients wants to buy a CAT scanner, is there any legal bar against his doing so?

Mr. BOGUE. Do you mean right now?

Mr. CARTER. Or could there be without a constitutional amendment?

Mr. BOGUE. I do not think that there is a legal difficulty with that. If there were, I guess the planning law would be unconstitutional, and it has already been upheld, as you know.

Mr. CARTER. This part of it I would not think would have been upheld, and I do not think it would be, if that were tried. So long as the man did not accept federally financed patients.

Mr. BOGUE. I do not know whether I want to get into a legal argument here, but I think you clearly could impose that kind of requirement under the commerce clause of the Constitution. I do not think there is much difficulty with that.

I do not think it is something that we could settle right now. I think the court has been presented with that issue and decided in favor——

Mr. CARTER. I do not think they have decided that particular issue. I would like to see it, if you have it included for the record, and I do not believe it is constitutional. I think that is a sort of freedom of choice thing. If a man has private patients and if he does not accept those who are funded by medicare and medicaid—I doubt it, seriously.

Thank you, Mr. Chairman.

Mr. FLORIO. Thank you very much.

The committee will reconvene at 2:00 p.m.

[Thereupon, at 12:15 p.m., the subcommittee recessed, to reconvene at 2 p.m. this same day.]

AFTER RECESS

[The subcommittee reconvened at 2:25 p.m., Hon. James J. Florio presiding.]

Mr. FLORIO. Ladies and gentlemen, Chairman Rogers will be here in a few moments, but he has asked me to reconvene and to get started, because we have a long agenda for this afternoon.

The next speaker is Frank J. Jirka, Dr. Jirka, of the American Medical Association, vice chairman of the Board of Trustees.

Is he here?

Doctor, perhaps for the record you would like to introduce your associates?

Dr. JIRKA. Yes, I shall, sir.

STATEMENTS OF FRANK J. JIRKA, JR., M.D., VICE CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, AND ARCHIE T. JOHNSON, M.D., AD HOC COMMITTEE ON PLANNING, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, LEGISLATIVE DEPARTMENT; AND DAN HILL, ASSISTANT DIRECTOR, LEGISLATIVE DEPARTMENT

Dr. JIRKA. I am Frank J. Jirka, Jr., vice chairman of the Board of Trustees of the American Medical Association and a practicing physician from Chicago, Ill. With me today is Dr. Archie T. Johnson, a physician from Raleigh, N.C. Accompanying us are Mr. Harry N. Peterson, director of the AMA Legislative Department, and Mr. Dan Hill, assistant director.

We are pleased to have this opportunity to express the views of the association on H.R. 10460 and other proposed revisions to Public Law 93–641, the National Health Planning and Resources Development Act.

We note that H.R. 10460 would extend for 4 years and would expand the act. Mr. Chairman, the American Medical Association supports health planning as an important element in the efficient, effective delivery of high-quality medical care to patients. The planning process must be a rational one in order that the availability and the quality of care not be adversely affected by inappropriate decisions concerning the needs for services.

We believe that health planning must be flexible enough to accommodate the different medical needs of various communities and of the individual patients, and thus, to insure the availability of high-quality medical care for all persons. This is achievable best by placing the planning authority and power at the local level and by insuring that those most directly involved in, and knowledgeable about, the use of medical services at the local level are heavily involved in and have the basic responsibility for making decisions regarding the quality, distribution, and availability of services.

Public Law 93–641 as presently written and implemented does not provide for appropriate local determination. The AMA urges its repeal. New legislation, premised on the basic principles we have briefly outlined above, should be developed.

However, we recognize that since current program authorizations will soon expire, a complete legislative overhaul may not now be possible within the congressional budget timetable. We therefore suggest amendments [see p. 369] that would move the planning law more in the direction of responding to patient needs by limiting Federal power and by shifting authority and responsibilty for planning back to the local community.

We believe that the amendments in H.R. 10460, as well as those which we understand to be under consideration by the administration, would not achieve the desired goal, but would, instead, impose additional limitations and ration health resources. We urge Congress to reject any amendments that would inhibit the delivery of high-quality medical care.

Attached to our statement is a listing of AMA-proposed amendments. Those amendments, if adopted, would, in our opinion, more nearly achieve the objective of local planning and we request your careful consideration of them.

Because of time constraints, our comments today will be limited to only certain of the amendments proposed by the AMA and others.

Mr. Chairman, three major proposals found in H.R. 10460 cause deep concern. These are: The extension of certificate of need to physicians' offices; the decertification of health facilities; and the revisions to title XVI. If these proposals are adopted in combination with other regulatory provisions, they could lead to strong Federal control over the development and operation of the health-care delivery system.

As this subcommittee is aware, the National Commission on the Cost of Medical Care, an independent commission sponsored by the American Medical Association, has recently issued its report containing a series of recommendations in response to concerns about rising health-care costs.

This report has been circulated to Members of Congress and to various elements of our society. The American Medical Association has also distributed the report to its constituent societies in the medical profession.

The AMA is currently reviewing and analyzing the recommendations made in the commission's report, and in evaluating the recommendations, will have the benefit of wide input.

Several of the recommendations in that report touch upon subjects which are before the committee.

H.R. 10460 would require extension of certificate-of-need to the physicians' office by covering purchases of major medical equipment.

Such a step represents a dramatic extension of the planning law and must be examined most carefully. Any hasty action could have long-range, unintended effects.

For example, restriction of the physician's use of new medical technology could clearly impede development.

One of the subjects of the commission's report relates to the extension of the certificate-of-need to physicians' offices. This recommendation states:

> If certificate-of-need—(CON)—legislation proves to be effective as a cost-containment technique for in-patient institutions, then for the sake of consistency: Expand CON to provider settings outside the hospital, including private physicians' offices, in order to provide coverage for a new facility or service that is being proposed for a noninstitutional setting, and one that substantially duplicates the facilities or services offered in the institutional setting. This certificate-of-need expansion should not include expenditures for replacement equipment.

It must be observed, however, that the recommendation is a qualified one. That is, the extension is premised upon a finding that must first be made that certificate-of-need is shown to be effective as a cost-containment measure.

There is as yet little evidence to support the notice that certificate-of-need results in significant cost savings, even for those services presently covered.

Until such evidence is compiled, the extension of certificate-of-need, as proposed, would be inappropriate. Moreover, we all must recognize

that cost considerations cannot be isolated from the necessity of maintaining quality.

The committee will recall that it recently rejected a similar provision when it considered hospital cost-containment legislation. The issue was carefully considered then, and we see no reason why this subcommittee should not reject this proposal again, pending careful review and study by all interested parties.

Other recommendations of the commission's report call for experimentation of regulatory controls before any widespread adoption. In this regard, several States have adopted programs which can provide a basis for obtaining experience with certificate-of-need for equipment in physicians' offices.

Moreover, Mr. Chairman, as to the current law, we offer an amendment that would make certificate-of-need for institutional services a State option. Far better, we believe, than any coercive force by the Federal government would be a system that permits the State to elect whether or not to enact a certificate-of-need law. Permitting States to seek alternate mechanisms could lead to other, very effective planning tools.

However, under the restrictions of current law, such experimentation is precluded, and we may never know if better solutions await discovery.

We are also concerned by proposals mandating decertification of services. H.R. 10460 contains a provision that would require States to develop a program to discontinue health services determined to be inappropriate. The Secretary would have the authority to determine what services would be subject to appropriateness review.

Decertification would be based upon national criteria issued by the Secretary. The Secretary could require compliance under the threat of severe penalties on the State or the HSA.

Mr. Chairman, can we easily forget the recent attempts by HEW to establish mandatory standards through issuance of the national health planning guidelines? Does this subcommittee wish to endorse such an authority by HEW? Is the subcommittee prepared to decide that HEW can better make decisions as to what services are needed in the community than the community itself?

Does Congress know the potential effects of the currently proposed guidelines—does HEW?

Is Congress willing to gamble with the future health care in the country in the absence of any experience that may be gained through presently unproven HEW guidelines?

We cannot answer these questions, but we believe that they should be before drastic measures are taken. Again, the cost commission report itself recommends decertification or conversion, but only if certificate-of-need programs prove effective. We believe that the certificate-of-need program should be studied carefully before supporting decertification.

Certainly, pending the results of such studies, there can be little justification for the broad authority for decertification as contemplated in H.R. 10460, and such provisions should not be adopted.

At this time, Mr. Chairman, Dr. Johnson will continue presentation of our statement.

STATEMENT OF ARCHIE T. JOHNSON, M.D.

Dr. JOHNSON. Mr. Chairman, members of the subcommittee: Public Law 93–641 is ripe for change. As Dr. Jirka has indicated, the AMA has developed several amendments to this law which we believe will go far to insure that health planning can enhance, rather than inhibit, the quality and availability of medical care.

At this time I would like to review some of our major proposals. I will then conclude our remarks by commenting on the title XVI amendments proposed in H.R. 10460.

As we earlier stated, planning decisions should be made by those most interested in, and knowledgeable about, health services. Major sources of such knowledge are the practicing physician in an area.

While current law makes limited provision for the representation of providers on HSA governing boards and other planning bodies, the present requirements seem to discourage, rather than enhance, physician participation in the planning process.

Since rational planning requires a firm base, it is unreasonable, and the stakes too high, to discourage from involvement those most knowledgeable about the health system. Therefore, we are proposing amendments that would require specific percentages of practicing physicians be members of the HSA governing bodies, State health coordinating councils and the National Health Planning Council.

Closely associated with questions relating to proper representations of providers is the troublesome aspect created by the separate classification and definition of "indirect provider." While the law provides for "provider" representation, this requirement may be filled, in large part, by "indirect" providers whose characterization as a provider is very tenuous.

Under Public Law 93–641, which sets up two classes of representation—providers and consumers—those termed "indirect provider" should more accurately be included as consumers. If this is not done, or if the definition is not deleted, this will restrict the full participation of many citizens—physicians, dentists, nurses, and so on, whose participation should be encouraged.

We are pleased to note that the Congress is considering easing some of the restrictiveness of this definition. This is a positive step toward encouraging all interested citizens to participate in local planning decisions. Such decisions can only make health planning more effective and more acceptable to the community.

Unfortunately, easing of the definition does not go far enough to solve the problem. The classification of "indirect provider" should be deleted.

The proposed "National Guidelines for Health Planning," published by HEW in September 1977, and recently revised, are another indication of increased federalization of the planning process. The apparent mandatory nature of these proposals undermines any notions of community-based health planning.

Of even greater concern are proposals that are reflected in H.R. 9717 that would clearly and unequivocably empower the Secretary to set maximum and minimum standards for local institutional health services.

We object strongly to this proposal. It would insure that HSA's would merely be the enforcement mechanism for planning decisions made by HEW.

Control of institutional health services by the Federal Government would be totally contrary to the provision of high-quality medical care and to local determination of need. Such enforcement authority—authority which HEW presently claims it does not have and authority against which many individuals, including Congressmen, protested concerning HEW's attempted national health planning guidelines—should not now be countenanced by Congress.

However, we do believe that the Federal Government can, and should serve, a useful advisory role to help planners. In this regard, it can be appropriate and helpful for HEW to issue true guidelines for health planning. However, since local initiative and flexibility are the hallmarks of a successful planning effort, Federal guidelines must not preclude community-based determinations of health resources needs.

In keeping with this belief, the amendments which we have offered would allow HEW an appropriate advisory role in health planning, while precluding the preemption of local decisionmaking by Federal officers. Adoption of these amendments would, we believe, allay many of the fears aroused by HEW's proposed guidelines and would be a positive effect towards assuring political self-determination.

In 1974, the AMA testified on S. 2994, the National Health Planning and Development Act of 1974. Reviewing the extensive powers of the Secretary that were then proposed, we said:

> Even more ominous in this regard is the heavy hand of the Secretary of HEW in the regulatory process. If he is to be the health care czar, will he have counterparts relating to other sectors of society.

Experience with proposed guidelines tells us that the Secretary will seek, as we predicted, to maximize his control over planning the delivery of health care services at the expense of HSA's, institutions, and practitioners, and especially at the expense of patients.

We are extremely disappointed that none of the proposals being considered would reverse the aggrandisement of Federal control. In fact, certain recommendations would insure the Secretary's status of health care czar. This ever-increasing Federal regulation of health care is inimical to the best interests of patients.

Health planning decisions must be made locally, both to be effective and acceptable. Our proposals are aimed at restoring to local communities the decisionmaking power in health planning and, more importantly, are specifically aimed at curbing the excessive powers of the Secretary. We cannot emphasize enough the need, at this time, to realine the planning program by circumscribing excessive Federal authority as a fundamental step in assuring a rational determination of need for health resources based on community and patient needs.

Certain activities in the planning process are already subject to public scrutiny and comment, such as the development of health systems plans. However, other actions are not subject to such review, and we think they ought to be. In particular, the development of the annual implementation plan should be subject to public hearings on its content. We are pleased to see that the subcommittee is considering an amendment that would achieve this and we urge its adoption.

We also urge that any changes in the HSP suggested by a statewide health coordinating council be subject to public hearing and review. Since an HSP is a locally developed product, the citizens involved in its preparation should have a reasonable opportunity to comment on any proposed changes.

Current law requires that HSA records be open to the public. The provision has been a nuisance to some HSA's as they try to decide which records are included. We are also concerned that HSA's may have some data that could identify individual patients.

This could become especially troublesome as HSA's obtain further data from PSRO's, as is now required by law. We suggest that the mandatory exchange of data between HSA's and other organizations, especially PSRO's, be amended, so that the holder of the data have some flexibility in deciding whether or not to release confidential medical information.

We also urge inclusion of confidentiality provisions in Public Law 93–641 to limit public access to records that should remain confidential in order to protect the privacy of the subject of these records.

We note that the subcommittee has before it an amendment to clarify these provisions, particularly in regard to HSA personnel records. This is a positive step; however, the protection should be extended as we have outlined.

We note with extreme concern another amendment contained in H.R. 10460; in relation to title XVI, pertaining to health resources development. That title replaced the old Hill-Burton program for Federal assistance to facilities construction. The present title XVI provides, in part, for State development of a plan establishing priorities within the State, identifying needed construction and modernization, and for allotments of Federal funds among the States for implementing State plans.

The amendments of H.R. 10460 would repeal two main provisions of title XVI which give a primary role and initiative to States, and would substitute a new program wherein the Secretary would directly determine priorities for funding among all applicants from all States, and would make grants, loans, and loan guarantees directly from the Secretary rather than from funds allotted by States:

We believe that title XVI, because of its present interdependence with title XV, should be extensively revised, but retaining the emphasis in the important role of the State as occurred under the Hill-Burton program.

However, the amendments proposed in H.R. 10460 would substantially eliminate the State role under the title XVI program. Adoption of the amendments of H.R. 10460 would remove authority of the State to establish priorities among applications within the State in relation to specially allotted funds for each State. Applications from all States would then compete for whatever funding was made available.

The Secretary would decide what types of applications would have priority according to his own determinations. Could not all applications from some States—applications for otherwise worthy projects for that State—be permanently denied?

We believe that these amendments would undesirably concentrate in the hands of the Secretary excessive power to establish standard-of-need applicable on a local level. The authority of the Secretary to establish priorities by regulation and to choose the individual projects to be supported is entirely too broad.

Is this not inconsistent with strengthening local determinations?

These amendments to title XVI should not be adopted.

In conclusion, Mr. Chairman, there are many areas of Public Law 93–641 that are ripe for change, and we have attached a summary of amendments believed necessary. We are prepared to meet with you and your staff to discuss the specific language of these proposals.

I would like to point out at this time, Mr. Chairman, that physicians around the country have participated in the planning process and have given thousands of hours to the planning process. We believe that those items addressed today are fundamental to making the health planning system more responsive to the needs of each community.

By being so responsive, health planning can better achieve desirable objectives.

Mr. Chairman, barring a clean slate in this area, we believe that our proposals will help make the health planning system more responsive to the unique needs of patients based upon local determinations, as was the original intent of Congress in Public Law 93–641. By the same token, we believe the subcommittee should not adopt H.R. 10460 in its present form.

Mr. Chairman, we would be pleased to answer any questions which the subcommittee may have.

[The amendments referred to follow:]

RECOMMENDED AMENDMENTS TO P.L. 93-641, THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT.

A. Issuance of National Health Planning Guidelines

Amendments are designed to make clear that any national guidelines issued by the Secretary of HEW are not to be mandatory standards. Guidelines would be advisory only and HSAs would have flexibility in the design of their local plans.

Another amendment would require consultation with certain professional parties before issuing any guidelines rather than allowing interpretation by the Secretary as to when consultation would occur.

B. Definition of Provider and Health Care Facility

The current definition of "provider of health care" would be amended. The term "indirect provider" would be removed. Thus only "direct" providers would be considered as providers.

The definition of health care facility would also be amended specifically to exclude a physician's office.

C. Representation of Physicians on Planning Bodies

Amendments would establish a required representation for practicing physicians on the National Council for Health Planning and Development (at least 4), on State Health Coordinating Councils (SHCCs) and on HSA governing bodies (at least 50% of the providers on each body).

Another amendment would reduce consumer representation on the HSA from a majority to 40%.

D. State Rate Review Programs

This amendment would delete federal funding authority for establishment of State rate review programs.

E. Certificate of Need and Appropriateness Review

A basic concern with P.L. 93-641 is that certificate-of-need (CON) laws must be adopted by all states. Amendments would make CON a state option. In addition an amendment would require a study of the effects of CON programs.

Other amendments would delete present provisions relating to HSA and State "appropriateness" review of institutional health services.

F. VA and HMO Representation

Amendments would delete required VA or HMO special representation on HSA governing bodies and SHCCs. Such representation would thus be the choice of the particular body.

G. Confidentiality of Data

There are inadequate provisions assuring the confidentiality of data gathered or held by HSAs. Since some of this material may be sensitive patient information, it is desirable to have proper protection. Changes to the law would provide for HSA protection of confidential information.

H. Modification of Secretary's Authority

Other changes would eliminate the extensive review authority of the Secretary over functions and operations of the HSA and the State Agency.

I. Uniform Reporting and Centers for Health Planning

The Secretary is presently authorized under P.L. 93-641 to establish uniform cost accounting and reporting systems, a uniform system for rate calculation, and a system for classification of health services institutions. Because of its duplication in recently enacted P.L. 95-142, this subsection would be deleted in P.L. 93-641.

Another amendment deletes authority for Centers for Health Planning.

J. Penalty for State Failure to Designate State Health Planning and Development Agency (SHPDA).

Presently any State that fails to enter into an agreement with the Secretary to designate a SHPDA will lose all Public Health Service Act funds within the State as well as funds under the Community Mental Health Centers Act and the Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act.

An amendment deletes this penalty.

K. Review of Grant Applications

Under current law, HSAs would review and approve or disapprove applications for funds under a number of grant programs. The provision would be amended to permit HSAs and SHPDAs only to review and comment on such applications; they would not have the power to approve or disapprove. Since the Secretary of HEW in any event has final approval of an application, the amendment would assist primarily in hastening the review process by establishing specific time limits for review.

L. Payments to HSAs

Under current law, HSAs receive their funding almost completely from the federal government, thus insuring a tight rein on their activities by HEW. Sharing the costs between the federal and state governments (or other non-federal sources) would lessen HEW's control and give to the states a greater voice and interest in planning activities.

Amendment would limit the federal share of HSA costs to 75 percent. Maximum flexibility would be permitted in making up the other 25 percent. In addition a total federal dollar limitation (based on a per capita calculation) is imposed on the HSA.

Another amendment would delete the Area Health Services Development Funds which provide for development of projects by the HSA -- an unnecessary and undesirable function by the HSA.

M. Authority of the Secretary of HEW

The powers of the Secretary in the planning process are such that he can exert great control over HSAs, SHPDAs and SHCCs.

A series of amendments would lessen the authority. One amendment converts the present "National Health Priorities" into items for "consideration" rather than "priority consideration".

Another amendment removes the mandated number of HSA staff and allows for contracts with consultants.

A third amendment allows approval of a State administrative program "substantially" meeting required conditions rather than absolute compliance.

Another amendment removes authority of the Secretary to review the HSA plans.

N. Hearing Requirements

One amendment would subject an HSA's annual implementation plan to hearing and comment. A second amendment requires that an SHCC, before revising an HSA's plan, have a public hearing on the revision.

O. Designation of Health Service Areas

This series of amendments affect the designation procedures for health service areas. One prohibits interstate HSAs unless the Governors of all the States involved agree to an interstate designation.

Two other amendments give Governors the final approval over designation of HSA boundaries and provide a mechanism for revision of boundaries.

P. Federal Facilities

An amendment would subject federal facilities to the same considerations of certificate of need as may apply to non-federal facilities.

Abbreviations

HSA	-	Health Systems Agency
SHCC	-	State Health Coordinating Council
SHPDA	-	State Health Planning and Development Agency
CON	-	Certificate of Need

Mr. FLORIO. Gentlemen, thank you very much.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

As I understand it, you are not a believer in the certificate-of-need program, is that correct?

Dr. JIRKA. We believe it should be a State option, Dr. Carter.

Mr. CARTER. Letting the State have the option on certificates-of-need.

What about inclusion under certificate-of-need that we now have on physician's offices for purchases of equipment over $150,000. Do you think that that is essential?

Dr. JIRKA. We now have in physician's offices?

Mr. CARTER. Would have, in this legislation.

Dr. JIRKA. Oh, would have. Dr. Carter, we are opposed to such an extension of the certificate-of-need into the physician's offices, because there has been really no evidence to the present time that certificate-of-need has had a cost saving effect.

Mr. CARTER. Are there many CAT scanners in physicians' offices throughout the country—computerized axial tomography?

Dr. JIRKA. To my knowledge, there are not all that many, Mr. Chairman.

Mr. CARTER. Not very many in physicians' offices. They are rather expensive machines, costing about how much?

Dr. JIRKA. To my understanding, around $700,000.

Mr. CARTER. Yes, sir.

But if we place a cap on what a group of physicians could purchase, would we ever have another Oxner's or Mayo's or Prouse or Joslin's or Lahee's Clinic?

Dr. JIRKA. That is one of our concerns, Dr. Carter. If you, in essence, and hopefully unintentionally, stymie technology, or limit the production or the purchase of a product, in my opinion, you stymie advancement in the field of medicine.

Mr. CARTER. Yes, sir.

You would, though, support the efforts of HSA's, and the allocation of exotic equipment, would you not?

And, as I mentioned this morning, I do not know if you were here or not, St. Anthony's and Baptist's Hospitals in Louisville, Ky. have, together, a computerized axial tomography machine.

Do you support such cooperative efforts as this?

Dr. JIRKA. For institutional use, yes, we do, Dr. Carter. I think you find many of your hospital medical staff now working with the administrations of hospitals in promoting cooperative efforts in sharing of institutional equipment.

Mr. CARTER. Do you think that physicians, dentists, nurses, hospital administrators, are sufficiently represented on the HSA's?

Dr. JIRKA. As direct providers, I would say no, sir.

Mr. CARTER. However, what do you think about the present consistency, or constituency, of our HSA's? How are they now constituted? Do you think they are viable organizations at present? Are they doing a good job?

Dr. JIRKA. Well, I would prefer to refer this to Dr. Archie Johnson, because he has had more experience in this particular area, Dr. Carter.

Dr. JOHNSON. Dr. Carter, I might say that I was involved in the planning process in North Carolina from the beginning at the request of the Governor. I helped him set up the health service areas and their boards, and have served as chairman—and still serve as chairman—of the State health coordinating council for the State of North Carolina, which, I understand, was the first, or one of the first, to get going.

I make that point only to indicate that I have been active in that area, and I would say that it varies from HSA to HSA and from State health coordinating council to state health coordinating council.

As I indicated in my remarks, I think certainly physician representation is not adequate in many of those areas because of the definition of indirect provider. This would be modified by one of the amendments we have, and I think that it would add a great deal to the planning process.

Mr. CARTER. Some people maintain that providers control the HSA's. Do you think that is true?

Dr. JOHNSON. No, sir, I do not. I heard that remark made this morning. I find that every time I go to a State health coordinating council, there are a majority of consumers there, and they are very knowledgeable consumers, certainly in our situation. I do not find provider control to be true, no, sir.

Dr. JIRKA. Dr. Carter, I think, if I could also refer to testimony this morning, that it was a witness from the American Health Planning Association who stressed the value, the great value, of provider representation on the HSA's. She related the very desirable interaction of consumers with providers, and especially commended the necessity; she pointed to the necessity, of having provider input into HSA's decisions.

I think that was emphasized by that witness this morning.

Mr. CARTER. Yes, sir.

You do not believe in decertification of hospital beds?

Dr. JIRKA. No, sir, not mandatory.

Mr. CARTER. If a hospital has an occupancy rate of 60 percent continuously, would you advise that something else be done with the beds, some alternative?

Dr. JIRKA. I would think that if we can still retain the highest quality of medical care at a more reasonable cost that certain shifts in the services should be considered, yes, sir. But I strongly feel that this is a multifaceted problem.

First of all, what will this do with staff affiliations by the practicing physicians? I think it was alluded to this morning that the quality of medical care has been the responsibility and has been carried out well by examining committees within hospitals credentials committee, if we may call them so.

The political realities of life, as they relate to the organizations or the bodies that will have responsibility to determine what hospital will be decertified or what services will be shifted, I think is a matter of fact. The amount of funds shifted from one area to another, the grants, and so forth, have a tendency to compound and make this problem even more complex.

I think this is a multifaceted problem. I feel very strongly that, before one should venture into a national type of decertification

philosophy that there should be a more indepth study of the various potential obstacles, if I may use that term, that may not necessarily be surmountable.

Mr. CARTER. On that, where you have an obvious problem—where there have been population changes, as we are having throughout the country and if we do have beds that are not used, say 40 percent over a year, would you consider using them as skilled care, intermediate care, personal care beds, if the HSA thought it advisable?

Dr. JIRKA. I think it is being done in some areas. I think it relates to the overhead and the amount of moneys received to run that institution, if certain portions of it are restricted or segmented into use for things other than acute care.

There is one thing, Dr. Carter, that mildly disenchants me today. I sat here listening this morning, about decertification, its relationship to cost containment, its relationship to communities, its relation to the political bodies, its relation to criteria, but I did not hear the word of what this is all about—my patients, and the other practicing physicians' patients in this country.

We have to take the patient into consideration. I think he should have, if not the highest priority, one of the highest priorities, because that is what it is all about.

Dr. JOHNSON. Dr. Carter, I might elaborate a little bit. As was mentioned in previous testimony this morning, to respond to your question, we are, in some States, in our State, looking at utilization of unoccupied beds as extended care facilities.

I might point out that certain regulations prohibit that. In fact, one of the recommendations that would be incorporated in our State health plan in North Carolina will be that regulations be eased and some flexibility permitted that would allow the utilization of these beds, because we do not have enough extended care facility beds in many areas, and patients often have to remain in acute care beds until one is available.

So the floating bed, or swing bed, approach would be very useful in doing what you suggested.

Mr. PETERSON. On that point, Dr. Carter, our Association has reviewed some pending legislation which would accomplish the purposes that you are referring to, and our board of trustees has endorsed the objectives in such legislation, so we would support that concept.

Mr. CARTER. You have endorsed——

Mr. PETERSON. There is some pending legislation, particularly applicable in rural areas where beds are not fully utilized in small hospitals, that would permit the swing use of beds for skilled nursing——

Mr. CARTER. Yes, sir. Yes, sir. I compliment you on that. I think that is wise.

Could you clarify the relationship between the Report of the National Commission and the official policy of the AMA.

Dr. JIRKA. Well, first of all, Dr. Carter, it began approximately 2 years ago. I think I have to give a little historical background so that there is a better understanding, and perhaps appreciation. The American Medical Association did act as a catalyst to bring together a group of individuals who represent various disciplines of our society, representing labor, government, the insurance industry, hospital associations, medicine and business.

This was a free-standing committee. They recently issued approximately 48 recommendations. These recommendations do not necessarily represent policy of any of the disciplines that the individual members of the Commission represented.

There are some areas that they may, and there are other areas that they may not. As far as the American Medical Association is concerned, all of these recommendations have been disseminated to our various constituent state societies and county societies as well as to specialty societies.

These recommendations will be deliberated at our House of Delegates meeting in June, and if there are changes in AMA policy, they will be considered at that particular time.

Mr. CARTER. Yes, sir.

I notice that there were three past presidents of the AMA on that Commission.

Dr. JIRKA. Yes, sir.

Mr. CARTER. I believe that is right.

A minimum of three, maybe more. Is that correct?

Dr. JIRKA. I will have to take a quick look.

Mr. CARTER. I believe that is right.

Dr. JIRKA. Yes, sir. You are correct.

Mr. CARTER. All right, sir.

Do you believe that the HMO's should be exempted from certificate-of-need?

Dr. JIRKA. No, sir.

Mr. CARTER. Really, you would not exempt them?

Dr. JIRKA. No, sir.

Mr. CARTER. Are you a strong believer in certificate-of-need? Do you accept that idea?

Dr. JIRKA. Once again, Dr. Carter, I think that the benefits derived from certificate-of-need have to be more clearly demonstrated prior to a 100-percent endorsement of the concept of certificate-of-need. We feel that if there is to be this particular type of legislation that this should be at the option of State government.

Mr. CARTER. You would not continue to build unneeded hospitals in a crowded area, an already over-crowded area, would you, Doctor?

Dr. JIRKA. Continue to build beds in over-crowded areas?

Mr. CARTER. Yes, sir.

Hospitals in an already over-crowded area, over-bedded area.

Dr. JIRKA. No, sir.

Mr. CARTER. Where you have a 60 percent occupancy, you would not think of permitting more construction, would you?

Dr. JIRKA. No, sir; as long as we maintain the highest quality of care for that particular area. I think this is another factor that has to be taken into consideration.

Mr. CARTER. Certainly I agree with you on the highest quality of care.

I would be happy to yield, yes, sir.

Mr. FLORIO. Dr. Carter just presented to you a hypothetical situation that if, you had underutilization in an area and there is an application, or someone desires to build a hospital in an area, how would you, regulate or inhibit someone from building in that area that has not got a need?

You have indicated that you have not got too much confidence in certificate-of-need. Would you leave that totally to the private discretion of the potential developers of the hospital?

Dr. JIRKA. I would say that it really should be a local issue.

Mr. FLORIO. Local, as far as local HSA?

Dr. JIRKA. Yes, sir, local planning.

Mr. FLORIO. I just find that ironic, because when the bill provides for local HSA determination for certificate-of-need for evaluation of physicians' offices, you do not seem to have confidence in the local government and you shift that off to the State.

Dr. JIRKA. That is true, as to the State option proposition.

Mr. FLORIO. With regards to decertification, the bill provides for a State plan and you have not got the confidence there. You say shift it back to the local government.

Title XVI, you say let's have the State.

I have difficulty finding out who you have confidence in.

Dr. JIRKA. I am having, Congressman, difficulty in understanding your question, because the shifting back and forth here has me a little confused.

Mr. FLORIO. Well, if I could continue, what you are saying is that you do not think that there should be certificate-of-need required to evaluate whether a hospital should be built in an area that is already adequately served. And you say that that is a local decision that needs to be made.

Then I asked you what does that mean, and you said local HSA. How would the local HSA make a determination outside of the certificate-of-need procedure?

Dr. JIRKA. Let me reiterate, and probably clarify.

Local HSA's, if I may use that term, should be the determining body as to whether or not a particular area builds beds or does not build beds. Consideration of the extension of certificate-of-need into the physician's office, I feel, should not be considered until after you have had enough information as to whether or not certificate-of-need does, indeed, reduce costs.

Mr. FLORIO. And the next point you made, with regards to certification, you indicated that the State plan that is required in the bill, was not something you felt was appropriate. There should not be—a bill that requires a State plan for decertification procedures. I thought I understood you to say that your amendments would eliminate that because you did not have confidence in the State plan for decertification requirements.

Mr. PETERSON. Mr. Florio, if I could perhaps add something as to the State plan reference, I think you will find our statement here, refers to title XVI, is not the so-called planning title, title XV, but has to do with the construction of facilities, the former Hill-Burton program.

In the present title XVI there is a State plan. Under that program, there is a State plan under which the State establishes the priorities for its projects for construction, and so forth. We strongly support that element. We support the State plan there.

Mr. FLORIO. Well, that is the confusion I have, because I accept what you just said. But with regard to decertification we are con-

cerned about proposals mandating decertification of services. This bill contains a provision that would require States to develop a program to discontinue health services determined to be inappropriate.

You therefore do not have confidence in State plans for decertification, but you are advocating, a State program for the utilization of the title XVI money.

Am I correct in your position?

Mr. PETERSON. The bill that you have under consideration would require the development of a plan under which the services that were found to be inappropriate would have to be terminated.

Mr. FLORIO. The State plan.

Mr. PETERSON. Now, what we are saying here, is that, as we also heard from other witnesses this morning, there are many problems that are involved in the decertification process, problems that we have just not had experience with in this country on a nationwide basis.

Now, the concern that we have in establishing a national decertification program is, and as we see what has happened recently, that the decertification criteria would be that criteria which would be national criteria as established through the Federal Government, and the Secretary of HEW.

We are concerned, very strongly concerned, with the application of such criteria at the local level which would result in decertification of services.

And I think it was that same principle, and that same reaction of the Congress, to the recent guidelines. This is the concern that we have. The effect that the imposition of such standards imposed as decertification criteria on the local level, could affect the quality of care and the availability of care.

I think that what we are saying also, if we have not indicated it, is that we feel that we need more experience with this concept before it is imposed as a national requirement in this act.

Mr. FLORIO. Thank you.

Mr. CARTER. Thank you, sir.

On that very thing, gentlemen, in cases where we do have too many beds, and we are using them at only a 60-percent occupancy level, or it seems that something should be done by the HSA.

Mr. CARTER. Some people estimate, and have almost set down in concrete, that we lose about $30,000 a year on each bed.

Of course, the HSA should decide if there is an under-use of those beds, as I see it, and perhaps with future Federal legislation or, in some cases, in States which already have it, they could use the beds for skilled, intermediate, or personal care, or decertify them entirely.

Of course, one hospital administrator testified this morning that if 10 beds in his hospital were decertified, it would not save any money at all.

But, again, the allocation of exotic equipment, do you not feel that in order to save money that we should have these located at strategic places throughout our cities and our country, and not too many of them? Enough, but not too many?

Do you agree with that?

Dr. JOHNSON. I would respond this way, Dr. Carter. I think—for instance, let's take the CAT scanner. That is the favorite right now.

Mr. CARTER. Take what?

Dr. JOHNSON. The CAT scanner. It is the favorite.

As you indicated a little bit earlier, and as we indicated, it is expensive. I think that, alone, has prohibited some of these CAT scanners from being in hospitals. We do not have all the answers yet on those. In the information I have seen, the cost is coming down on the CAT scanner. We still—there is evidence that, in some instances, it does reduce hospital stay, length of stay. But I think, equally important, it prevents invasive procedures in terms of arteriograms and other types of invasive procedures.

So I think the process itself, or the expense, as we go through this evolutionary period, will prohibit the kinds of things that you are talking about.

Mr. CARTER. Well, I am thankful, as I brought out, about the situation in Louisville where we had a shared facility, and I think that such things as that are necessary in order to save. We must share certain commodities, certain services.

Now, in the hospital where I worked for many years, I have delivered as many as five youngsters a week. But now, since they have the pill and other contraceptive methods, they do not deliver anywhere near as many. I have delivered five a night, as many as five a night. Now they are delivering perhaps five a week.

So we see that there is less need for maternity beds. And many of these needs are shrinking throughout the country.

Do you not think that we must take care of that situation?

Yes, sir.

Dr. JOHNSON. Dr. Carter, I agree that we should work together in a cooperative way to do that, and I will point out again, in the place that I am most familiar with, in North Carolina, there is, in one large city, that followed a voluntary planning process, where two services did consolidate.

Mr. CARTER. Yes, sir.

Dr. JOHNSON. In Winston-Salem, N.C., they consolidated their services, a teaching institution and a county hospital.

I will go a little further, again in the State of North Carolina. There was a high infant mortality rate. The local people, worked together, consumers and providers, to do something about the high infant mortality rate in that State, and this was before HSA's came along.

One hospital voluntarily agreed to close its obstetrical services, because they saw that that was the best. I still believe in the local answer to problems, and I think that people can work together to solve these problems. I agree with your concept.

Mr. CARTER. I certainly agree with you on that. I do not think that there are too many providers on HSA boards at the present time. The law legislates that you do not.

I do not believe HSA boards are provider-dominated—at least, I have not seen evidence of that.

Now, for instance, intensive infant care facilities. That is another very specialized service as are coronary care units.

In the case of intensive infant care units, we have to have highly skilled pediatricians and nurses in those units. In a city of 400,000, should every hospital in such a city have a unit such as that?

Dr. JOHNSON. I am a specialist in newborns and have worked in this area and have tried to work not to duplicate services. I think what we are talkinb about is a system of care.

Some refer to it as regionalization. I like to refer to it as systems of care.

Again, in Raleigh, N.C., where there are two hospitals doing deliveries, they have not sought to duplicate services, but to combine resources. Every hospital cannot have an intensive care nursery because of the expense, and this is what happened, again, in Winston-Salem, N.C.

So I would agree that every hospital cannot, and not every hospital wants it. But I think, through developing a system of care, working again at the local level, without a lot or arbitrary figures, that we can solve these problems.

We need advice and we need consultation, but we do not need mandates.

Mr. CARTER. I agree with you all the way, and certainly I do not like mandates either, and really, I feel that we have got to share these facilities in order to lessen the cost burden throughout the country.

I am always glad to see a pediatrician, one who takes care of the young, and it is very nice to have heard you.

Thank you.

Mr. ROGERS. Mr. Florio?

Mr. FLORIO. Thank you very much.

I am not going to go into a great amount of questions, just to observe that, in the same way that you perhaps chided some of the witnesses this morning for not paying what you thought was appropriate attention to the patient implicitly you seemed to be implying that medical care quality was not paid as much attention to as perhaps it should have been.

I am not sure that I agree with you, but I would also say that the other side of the coin is that we have got to be concerned about costs. The highest quality of care is of no value if you cannot afford it.

I would just suggest that maybe there is a point in the mid area that has to be reached between your own testimony and the testimony of some who we heard this morning. The fact of the matter is, in the 3 three years the health bill of this nation has gone from $104 billion to $139 billion. The status quo, clearly, will not suffice.

Certainly no one likes to talk about mandates, but the fact is that something has got to be done to reverse the existing situation, and quite frankly, gentlemen, all that I heard today was that we need more study and that we have to go back to the local level.

The fact of the matter is that most of the difficulties that we have now are as a result of the system, that I get the impression that you are saying is going to be something that we are going to have to rely upon, to a large extent.

I wanted to ask one specific question. Your comment said that you are adding to the percentage of physicians on the HSA, but it does not say what percentage.

Do you have a percentage suggested?

Mr. PETERSON. May I make a comment, just in observation on your first one?

Mr. FLORIO. Yes.

Mr. PETERSON. It was no intent, by virtue of the observation about this morning's witnesses, to imply in any way that they were not concerned about patient care. It was an observation that much of the testimony this morning dealt with other matters, but there was no intent that they were not at all concerned about patient care.

Dr. JOHNSON. As far as your question about the percentage, we would like to see, of the direct providers, 50 percent as practitioning physicians—of the direct providers.

Mr. FLORIO. In other words, 25 percent, or something less than 25, 24 or 25, as physicians, of the total HSA?

If it breaks down 51 percent consumers, 49 percent providers, you think——

Dr. JOHNSON. Half of that.

Mr. FLORIO. Half of that percentage.

Dr. JOHNSON. I would just say again that we are concerned about costs and many of us are working on various committees on cost containment. We realize this, and are trying to take the initiative to do something about it through various cost containment committees.

Mr. FLORIO. When you speak of physicians, are you talking about M.D.'s, D.O.'s, dentists? Would that fall into your 50 percent of the provider category?

Mr. PETERSON. That 50 percent physicians would be M.D.'s and D.O.'s.

Mr. FLORIO. I have nothing further.

Dr. JIRKA. Congressman, if I may, just so we do not leave with the feeling that American medicine is not concerned with cost, I think you are well aware of the fact that just recently the American Medical Association, in conjunction with the American Hospital Association and the Federation of American Hospitals, have formed a committee to attempt, on a voluntary basis, to reduce the cost of the delivery of health care to the citizens of this country.

Mr. FLORIO. You are talking about the hospital proposal was put forth as a result of Mr. Rostenkowski asking——

Dr. JIRKA. Yes, sir.

Mr. FLORIO. My only observation on that is that the bottom line is a suggestion that the hospitals voluntarily—and the medical people—voluntarily enact some practices and procedures that will restrain costs, but in fact legislation should be enacted so as to provide the hospitals and medical services with reimbursements by way of credits and by way of other tax incentives.

So in effect what we are doing is saying we are going to shift the costs off of the public sector.

Dr. JIRKA. That latter statement, I have not seen and I certainly would appreciate seeing it.

Mr. FLORIO. The last two paragraphs of the statement.

Dr. JIRKA. Well, I have searched through all the statements. Unless you have one that I do not have, Congressman, I would certainly appreciate seeing that particular phase of it.

Mr. FLORIO. Thank you very much, sir.

Mr. ROGERS. As I understand it—and I apologize to you that I had to be late for part of your testimony—you do believe that the cost of medical care is too high in the Nation?

Dr. JIRKA. That is correct.

Mr. ROGERS. Is that shared?

Mr. PETERSON. Yes, we are concerned very much with the rising costs——

Mr. ROGERS. Well, I understand that you have said that this is the problem that we have right now and that you are trying to address it. It is simply the technique for addressing it that you have some concern with.

So you and the hospital people both have said the cost of medical care is too high in the Nation, right?

Dr. JIRKA. Right.

Mr. ROGERS. So we are all agreed on that problem—the Congress, the American people, the AMA, the HSA's, the planning groups, everybody says it is costing too much to get medical care.

Now, as I understand it, you are saying well, let's don't plan, but just let us do it locally. I thought I understood that that was said, just let everything be voluntary.

Is that basically your approach?

Dr. JOHNSON. Mr. Chairman, we believe in planning, Mr. Chairman, on a voluntary basis, and I think, as I understood, the intent of the legislation initially—of Public Law 93–461 was that it be local planning.

Mr. ROGERS. Well, now, how do you get voluntary planning? How do you get them to do it?

Mr. PETERSON. Mr. Chairman, if I might add to this here.

Mr. ROGERS. Certainly.

Mr. PETERSON. The thrust of our statement here with respect to Public Law 93–641 expresses a strong concern about the national standards and the national control, the controls in the Secretary's office. And what we are saying here is that we think that the legislation should be amended to provide for more local determination.

This is not to say—and, as a matter of fact, our statement specifically says that there is a role for the Secretary and for the Federal Government to provide guidelines that the local HSA's may use.

But we do have——

Mr. ROGERS. I guess I did not hear your modification of the position in your statement when you urged the repeal of Public Law 93–641.

Mr. PETERSON. We have said, basically, that because the way the law is constructed at the present time we have recommended repeal, and that the law should be revised to provide for more local determinations.

Then we continue to say that, recognizing that the Congress would not have time at this time to fashion a new planning law, which may then incorporate the local basic planning principles more adequately, from our point of view, we have recommended a series of amendments which would be intended to strengthen the local planning process.

And in these amendments, in our statement, we have said that there is a role for the National Government and that guidelines that are

set down should be expressed as true guidelines for the local HSAs to use in their own planning process.

We are concerned.

Mr. ROGERS. I think we have no problem, then. Have you seen the new guidelines?

Mr. PETERSON. Yes, sir.

Mr. ROGERS. Have you seen that it is up to the judgment of the HSA and that they will be guidelines and not directives?

Mr. PETERSON. Well, we have some concern with these new ones, and I would like to express the reason why. We certainly understand and recognize that the standards, as such, have been modified.

Mr. ROGERS. It is not just standards, it is a whole concept.

Mr. PETERSON. Well, if I may——

Mr. ROGERS. Yes, you may. Have you read them?

Dr. JOHNSON. Yes, sir.

Mr. ROGERS. You have read them all?

Dr. JOHNSON. Yes, sir, several times.

Mr. ROGERS. Do you understand the difference—did you read the ones before?

Dr. JOHNSON. Yes, sir.

Mr. ROGERS. And do you see the difference now?

Dr. JOHNSON. I see the difference in the numbers.

Mr. ROGERS. What else have you seen? You saw no difference in the fact that it is a local judgment?

Dr. JOHNSON. I think that our concern is still the authority that rests with the Secretary.

Mr. ROGERS. What authority?

Dr. JOHNSON. Well, this is what I am getting at. Rather than get into—well, I would like, if these are guidelines, or benchmarks, or whatever——

Mr. ROGERS. Guidelines. Not directives. That is clear.

Mr. PETERSON. Mr. Chairman——

Mr. ROGERS. We said so in the statements when they introduced them. It says that the judgment is up to the HSA as to how they shall be applied in their area.

The Secretary can not even disapprove their plan? Did you realize that?

Mr. PETERSON. Mr. Chairman, is it the intent that the HSA's——

Mr. ROGERS. Well, now, just a minute. Let me hear from these doctors. You always want me to listen to doctors, and I want to hear doctors, not staff—although we welcome staff. I want to hear what these doctors know and understand and are saying.

Now, do you understand the difference? That the Secretary cannot even disapprove the plan of that HSA? Did you know that?

Dr. JOHNSON. In reading these, Mr. Chairman, again——

Mr. ROGERS. Do you understand that? That the Secretary cannot approve an HSA plan. Did you know that?

Dr. JOHNSON. Yes.

Mr. ROGERS. Is that not local judgment? Is that not local decision? Sir?

Dr. JOHNSON. To that extent it would appear so, yes, sir.

Mr. Rogers. Of course. And that is exactly—because we agree with you.

Now, somebody has been putting out the information, and I do not know where it comes from, to some of the medical profession that there is no local judgment, and that is exactly what this committee intended and wrote. I agree with you that the first guidelines were set forth more as directives, and this committee got concerned, and we had meetings with them, including the Secretary. They have changed them. They issued a new set. They have given every one another 30 days to comment before they even go into effect. And it makes it clear that the HSA makes the final judgment.

Now, we have agreement that local people ought to make the final judgment. I do not think we have any problem there.

National guidelines were required so that research could be undertaken on what are general problems, what ought to be reasonable goals, to try to meet. But if the conditions vary in one's area, that HSA can establish different goals.

Yes, sir?

Dr. Johnson. Mr. Chairman, before you came in, I indicated that at the request of the Governor of the State of North Carolina I helped establish the HSA's and the boards and so forth, at passage of Public Law 93–641. HEW came out with the business about certain criteria that must be met before an area could be considered as an HSA—that you had to meet certain requirements, but that there would be limited waivers.

HEW also went on to say that you should work with the PSRO's and so forth, and we attempted to do that. And we had eight PSRO's in North Carolina.

So, we wanted to have HSA's to work with the system we already had in effect. I came up here at the request of the Governor with the Secretary of the Department of Human Resources, met with HEW, and tried to find out.

They said no, you have to meet the requirements here, you go back and form six HSA's. So I guess I am a little gun shy and a little shellshocked about how flexible all of this new criteria is.

Mr. Rogers. Well, maybe at the beginning this may have been so, including wrong interpretation and intent. That may have been so.

It was not clear that decisions were to be based on the judgment of the local HSA which had been established, I understand, and that is what has been made clear, the planning group is to make the local judgment. You are talking about the decisions on how he is going to divide up the State into health service areas.

There was room for negotiation there, I think. Once the HSA is established, though, this judgment is left to them, and this is what we have tried to say, and that is the crucial part, to let the local areas do the planning.

Yes, sir.

Mr. Carter. On that, Mr. Chairman, you know that I amended the bill so that it could follow the concept that you mentioned—allowing eight different HSA's, if necessary—and to take into account the problems of a State, somewhat mountainous, as is the State I live in.

However, I must admit that HEW never did follow those guidelines, never did adhere to the law, the intent of the law, as best that I can tell. And, not only that, on the Floor of the House, the bill was further amended by Bill Alexander from Arkansas to help take into consideration local areas, and so on. But I have never seen that.

They have—I think, in your case, they must have acted in an arbitrary manner.

Mr. ROGERS. It may have been, and often they do act in an arbitrary manner. But what I am saying is, once your areas are established, which is the Governor's—that really was his basic decision, what we tried to get him to do.

Now, the Secretary had some say-so, we would agree.

But your HSA's are locally selected and they are locally to make the judgment. Now that is basically what you want, is it not?

Dr. JOHNSON. Yes, sir, we want local——

Mr. ROGERS. Judgment.

Dr. JOHNSON [continuing]. Judgment.

Mr. ROGERS. Now, with these guidelines, so the HSA can make that, what problem is there?

Dr. JOHNSON. As long as they are guidelines, as long as they are flexible——

Mr. ROGERS. Then you can be supportive as long as that is true?

Mr. PETERSON. Mr. Chairman, may I——

Mr. ROGERS. Now, just a minute. I am going to let you say something. I want to hear from a doctor.

Dr. JOHNSON. As long as they are guidelines, as long as they are not mandatory?

Mr. ROGERS. That is right. They can be changed by the HSA for their individual reasons, which is what we want. Otherwise, there is no point in having the HSA's. And this committee understands, and wrote the law that way.

So I do not think we have a disagreement.

Dr. JOHNSON. I do not think so, on the guidelines, as long as they are true guidelines.

Mr. ROGERS. I am delighted.

Excuse me. I would be glad to hear you.

Mr. PETERSON. Thank you.

We certainly do agree with you, Mr. Rogers, that the guidelines should be flexible and that they should be guidelines for the HSA. Now, if they were true guidelines, then it would seem that the HSA could make its own determination as to the variations from the guidelines, because these are merely suggestions in a sense, then——

Mr. ROGERS. Well, they really are kind of goals or guidelines that we hope people can reach.

Mr. PETERSON. And that is the way our amendment that we are suggesting would more clearly specify.

Mr. ROGERS. Well, it is not necessary. That is already what the guidelines are, if I may be permitted to say so, and it has just been clarified.

I do not think everybody has seen what was stated when we just got this change effected. It has just happened, you know. It has just come about.

So I think this is all settled, and I see no need for a change.

Mr. PETERSON. The language which gives us concern, Mr. Chairman, is the meaning of "consistent with." As you know, the law says that the plans must be consistent with the national guidelines, so in the regulations, they have defined the term "consistent with," and they have said that the local HSA plan, health systems agency plan, must—will be considered consistent with the standards set forth in subpart C of this part, where it (1) Establishes a goal which is not in excess of the level set forth in the standard, where that level is stated as a maximum; or not less than the level set forth in the standard where that level is stated as a minimum.

So it has to comply——

Mr. ROGERS. Except where?

Mr. PETERSON. I have not finished yet.

Mr. ROGERS. The three to four exceptions now.

Mr. PETERSON. And, (2) includes plans which, if implemented, are reasonably calculated to achieve that goal within 5 years, except where a specific adjustment is justified in accordance with subpart C.

Mr. ROGERS. All right.

Mr. PETERSON. So—if I may continue?

Mr. ROGERS. Read on, read on.

Mr. PETERSON. Well, that is the definition of "consistent with," and this is the area——

Mr. ROGERS. No. What are the exceptions?

Mr. PETERSON. Well, the adjustment which the HSA may make from the guidelines is based upon three elements, one of which you would have to find, and then it would be entitled to an adjustment.

Now, in creating this adjustment, it has to make a strong justification for it, and this justification goes up to——

Mr. ROGERS. Who said it has to be a strong justification? It has three exceptions. Will you read the exceptions in the law?

Mr. PETERSON. The exceptions that you are referring to, Mr. Chairman, are on page 3064 in the rules and regulations. You may have a different copy.

And where one of these three elements is found, then the HSA may make a justification for an adjustment. One of these is where the residents in the health service area do not have access to necessary health services.

Mr. ROGERS. All right, that is one.

Mr. PETERSON. And second——

Mr. ROGERS. Residents of the health service areas not having access. In other words, whatever facility is needed according to the HSA, no matter what the guideline says, no matter what the bed situation guideline says. If the population does not have access to hospital beds they are entitled to have those facilities. Broad, broad judgment of HSA.

That is just one of the exceptions. A second is "Significantly increased cost of care for a substantial number of patients in the area."

In other words, it is going to cost too much. You have to have more facilities, you have to be more available. We have to have more CAT scanners because the cost of travel to the patient is too

much there, and we have to have a clinic here, or another hospital, because the cost is too much for those people.

So that is in the judgment of the HSA—local judgment.

Third, "The denial of care to persons with special needs resulting from moral or ethical value." Church schools, church care, any other kind. Broad judgment. Anything you need, as a matter of fact, is that they are saying.

Mr. PETERSON. If I could carry that a step further, Mr. Chairman, once the HSA has created this adjustment in its plan, then it goes forward to the State agency and to the State coordinating council. Then it says here that the adjustment "may" be made part of the State health plan. Unless it is made a part of the State health plan, no certificate of need could issue.

And so the question——

Mr. ROGERS. Well, now, just a minute. Do you know how a State plan is made up?

Mr. PETERSON. It is made up of the local HSA's plans.

Mr. ROGERS. Of course. It comes directly from the plans or the local HSA's.

Mr. PETERSON. We would prefer then if it said that it "will" be made part of the State plan, rather than say "may."

And I think, Mr. Chairman——

Mr. ROGERS. Well, now, we can get into semantics.

Mr. PETERSON. Of course.

Mr. ROGERS. We can go "may" or "shall" and so forth. But, nevertheless, what we have here is that the local HSA makes up its plan and it makes the adjustment.

Mr. PETERSON. We are in agreement with what we would like to see the words say, and I think, Mr. Chairman, if the language provides any type of potential for misinterpretation as to what the committee's intent might be we would hope that it would be clarified during this comment period, because we would like to see them truly state that they are guidelines and the HSA——

Mr. ROGERS. I think it has been made quite clear that they are, and that this is the intent. In fact, I think that this has been acknowledged by HEW.

Dr. JOHNSON. Mr. Chairman, when I read these I read these without any consultation, and the thing that I had a question about is that in the first regulations in September——

Mr. ROGERS. Well, these are changed.

Dr. JOHNSON. Yes, sir, I know that. But they talked about guidelines and here they talk about standards, and I was confused. If they are guidelines, they are guidelines. Standards have a stronger connotation to me.

Mr. ROGERS. It is changed. It is up to the HSA to make the judgment, and that is why it is written this way, that it is up to the HSA to make the judgment.

The Secretary said that. Mr. Califano—believe it or not.

So anyhow, I do not think we have any difference. I am glad you can support planning where we are having HSA's make local judgment.

Now, are there any other areas that are of concern? I think the boards, you were concerned about providers, being sure that we have sufficient providers.

Perhaps, for instance, insurance companies, maybe they ought to be consumers. Should they? They purchase?

Mr. PETERSON. I would think so, rather than providers.

Mr. ROGERS. We would be glad to look at your suggestions there.

Are there any other suggestions?

Mr. PETERSON. We would be very happy to work with the committee in our suggestions——

Mr. ROGERS. Excuse me?

Mr. PETERSON. I say we would be very happy to suggest specific language to put our suggestions here into statutory language.

Mr. ROGERS. We would be glad to look at your language and any suggestions you have.

Mr. PETERSON. And to work with the committee.

Mr. ROGERS. We would be glad to have you do that. But the important thing is that I am glad you are willing to support the bill. These guidelnies—which they are—are simply guidelines and not directives to the local HSA.

Mr. PETERSON. Mr. Chairman, I think that is a rather broad generalization. As to the bill, we have pointed out other areas——

Mr. ROGERS. I thought that was what I heard the doctor say?

Mr. PETERSON. Well, we have——

Mr. ROGERS. Are you, the staff person, now telling me that the doctor's testimony is not correct?

Mr. PETERSON. I agree with what he said. What he said was that we were supporting local planning and we would support that the guidelines should be true guidelines, while there are other areas in the bill——

Mr. ROGERS. I understood that in the planning legislation, if guidelines are simply guidelines, and the HSA's make the local decisions, then you would be supportive.

Is that not what I understood you to say, doctor?

Dr. JOHNSON. I think the statement indicated that we——

Mr. ROGERS. I do not want to put words in your mouth. I understood that to be the thrust of your statement.

Dr. JOHNSON. I am very careful about words being put in my mouth, Mr. Chairman. I think I said that, based on certain amendments, that— and I expressed our concern about getting these amendments so that there would be more local planning.

Mr. Chairman, I would say that we support local planning, and we support—and if these are true guidelines, or benchmarks, then that would satisfy us as to the nature of the guidelines.

Mr. ROGERS. Now, the hospitals, they tell me that doctors are responsible for increased costs in the hospitals. Are they?

Dr. JOHNSON. They have not told me that, Mr. Chairman. We have been working very closely——

Mr. ROGERS. Which administrators have you been talking to?

Dr. JOHNSON. A good one.

Mr. ROGERS. I have just met with some, and heard that.

Dr. JOHNSON. Well, the hospital administrators that we work with, we are working together jointly. We see this as a joint effort to control health care costs.

Mr. ROGERS. Well, it is not there because you ordered the tests, you ordered the beds, you ordered the blanket that cost $250 to keep a patient warm or cold and so forth and so on?

Dr. JOHNSON. I would be glad to discuss that with any hospital administrator, Mr. Chairman.

Mr. ROGERS. Well, I have just been quoting a doctor who was an intern in my office and is now chairman of the committee at Jackson Memorial Hospital who said he could not believe it. He said as soon as he found out the cost, he never would have prescribed it.

What I am saying is that I agree with you; it is a joint problem. I am delighted that the AMA has said that they want to join in a voluntary program and get the doctors conscious of cost. Because I do not think it is stressed in the medical schools; we need to do that, and this committee is trying to encourage that in medical schools, because it is going to take everybody working together.

Now, we have tried to set up a reasonable approach to plan for the future. Surely, everybody agrees that we ought to do planning for health, do they not? Does anyone not agree?

All right. Now, if we can keep the emphasis on local decision, which I think we have, and we will follow it closely, because this committee is concerned with that, too.

Now, I think it is good to have some guidelines and some goals so that we can make judgments as to whether we are making progress or not, but if we allow the local HSA to make what judgments as are needed in that area, then we are probably moving in the right direction.

Would you agree?

Mr. PETERSON. Yes, sir.

Mr. ROGERS. Thank you. And we do look forward to working with you. We must have the cooperation of the medical profession, the hospital industry, and consumers to get on top of this problem. It is too important for people to go off on tangents, or on technical objections which really do not have much substance.

We need some leadership from the AMA in bringing about an effective planning program in the Nation.

Thank you for being here. Your testimony is most helpful and we do look forward to working with you.

Dr. JOHNSON. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you so much.

Dr. JIRKA. Mr. Chairman, we certainly want to work with you in our endeavors to have proper health planning in this country.

Mr. ROGERS. Thank you so much. We look forward to your cooperation.

We have a person who has to catch a plane; he is under pressure. He says he can make a very short statement, and if other witnesses would permit, I would call Mr. Art Gilman, who is chairman of the California Association of HSA's to come forward.

Mr. Gilman, we welcome you to the committee. Your statement will be made a part of the record in full, and if you could highlight it for us it would be helpful to the committee.

STATEMENT OF ART GILMAN, CHAIRMAN, NORTHERN CALIFORNIA ASSOCIATION OF HEALTH SYSTEMS AGENCIES

Mr. GILMAN. Thank you, Mr. Chairman and members of the subcommittee.

My name is Art Gilman and I am a farmer, by occupation. I farm in Butte County in California. I serve as the chairman of the 14-county HSA known in California as HSA No. 1.

I also serve as the president of the California State Association of HSA's, primarily because I show up oftener by anyone else, not because I have any special expertise.

I am going to depart from the prepared text. Certainly you can read that for yourself [see p. 391].

But, in response to the testimony you just heard, I found it very interesting, because in our 14-county area—and to give you a little idea, in case you do not know, we have 44,000 square miles in the 14 counties that embodies a little less than 600,000 people. And, as you can well see, they are pretty well dispersed, and we are what you call rural, when you get into our neck of the woods.

At any rate, we did have to speak directly to the question of why we should have certificate-of-need, and our organization is pushing in California, the legislature, to come on with a certificate-of-need program that will extend well beyond just the conventional providers, into all providers, as a matter of fact, of health care, into the equipment end of it, not necessarily the office.

About 3 months ago, we had an institution in a town called Reading, a town of about 30,000 people, make an application of a certificate-of-need for a CAT scanner. We looked at the area and, in that geographic area, about 100 miles in circumference we felt, in our best judgment, that there was need for a scanner.

And so it proceeded through the certificate-of-need process, through our HSA board, and consequently was approved and that approval was forwarded to the State director of health, as provided for under California law.

In the process of the 90 days that it took to complete the certificate-of-need, a private physician close by the hospital went out and bought himself a CAT scanner and set it up in business. Now we still felt that our original decision was right, and the appeal, which will be the first one in the State of California, will happen the day after tomorrow.

At any rate, the point I am trying to make is that, in those kinds of instances, we felt, and still feel, that because of the access in the hospital setting and the fact that it is available to everyone all of the time with the qualified people, certainly is superior over the setting in that private setting.

And, incidentally, the local medical society happens to agree with our opinion.

That points out the need that I have heard expressed here this afternoon.

Another area, and that is the lack of physicians on boards. I have had an opportunity to be invited to speak several times before our local Butte-Glenn Medical Society and I have pointed out to them

that certainly we, as lay people, need their help and expertise if we are going to make a reasonable community health plan.

But do you know, it is very difficult. I hear all of this expression of wanting to participate, but when board meetings happen, we have to have bodies and they have to devote the time, the same as I did. It is a 3,000-mile trip for me to come out here and they asked me Sunday to do this. That really did not give me much time to respond.

And I think that all of us, as volunteers and patients, I think that we are beginning to attempt to have a dialog with the medical profession, and they with us, and that is what I have tried to point out to them, that this is going to be a cooperative effort. If it is going to be worth its salt, then we are going to have to include all providers and some local government folks and certainly not forget about those of us who pay the bill—that is, the patient and the consumer.

The other thing I want to speak to you about, because I think tomorrow you are going to hear from a proposal to put forth more elected officials as a mandatory condition of HSA's. Let me tell you that I am a former county supervisor in our county and I am not any more because of my choice, not because of my constituents. But, at any rate, in being there—and I was involved in health planning as a supervisor—I think there is still a great deal of place for those people, for any elected official, either city councilman or school board members or supervisors or whatever level—but, again, they as physicians, must take the time to participate.

I think that in my own area—we have a 63-member board and I think we have 4 supervisors elected and a couple of city councilmen—but in our own area, they are absent about 80 percent of the time. Part of this may be that they have confidence in the consumers, or the rest of us and, as you can see, it is a rather large board.

At any rate, I would like to see the committee resist any attempt to water down that portion, because I think the present law, as it is presently structured, gives everyone, really, an opportunity to come. I have pleaded with them, and I still plead with them, to do that, because they are the only thing that is really going to make health planning, in my opinion, viable at the local level.

[Mr. Gilman's prepared statement follows:]

Testimony of Mr. Art Gilman
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Mr. Chairman and membersof the Committee:

My name is Art Gilman. I am an orchard and livestock farmer in Butte County, California, where I have served as a county supervisor, and am now the chairman of our local health systems agency. I also serve as the chairman of the California Association of Health Systems Agencies. I am speaking to you today on the basis of my various experiences and as a consumer, a volunteer, and especially a taxpayer.

My comments will be brief and blunt. I would like first to talk to the issue of the involvement of local elected officials at the HSA level. I understand that there is a proposal to make 25% of the HSA boards consist of elected officials and to make this a mandatory provision. The fact is that to do this would simply guarantee the absence of a quorum in many cases. In my own area our elected officials have been absent 80% of the time. There are other California HSAs where they have been unable to hold governing board meetings for months in a row because they could not get a quorum of county officials.

Do not think that I am against government official involvement. We strongly support and seek it. But elected officials should be treated just like anybody else. They should earn their own way, and their right to have power in the HSA structure should be conditional upon their responsibility to

follow through with the commitments and oblicagions involved. The present law and regulations contain more than adequate provisions for making HSAs accountable for the mix of their board membership. The State Coordinating Councils, the State Office of Planning and Resource Development, and the Regional Offices of DHEW all review these matters, and can pressure the HSAs to meet the standards of equity.

This means that there is simply no need to tamper with the membership provisions concerning elected officials. They already have adequate means for recourse. If they want more involvement, then let them prove they deserve it by attending meetings and becoming directly involved--which so far, in many cases, they have not bothered to do.

I am aware that the state and national lobbying groups for county supervisors are urging that more elected official involvement be mandatory, and even that all HSAs be put under the direct control of county governments. However, I have just spoken with Shannon Patterson, the immediate past president of the County Supervisors Association of California, and he agrees with me that there should be no more tampering with HSA structures at this time. Let those agencies which are public and governmental stay as they are, and get on with the serious work of doing health planning. The same goes for the public non-profit agencies--which is what they really are. Please, gentlemen, resist the pressures you are getting

to change HSA structures yet again. We need to do responsible planning, not more reorganizing.

In the same context, we would like to advise against any major shifts in responsibilities from governing bodies to governing boards in public joint-powers HSAs. We feel that this would compromise the planning process seriously, and give key powers over the planning process to governing board groups which are not likely to be as representative of providers and consumers as are the governing bodies, and which are not as likely to be knowledgeable, or even committed to attending the meetings and doing the necessary work--especially when the decision-making gets tough.

Next, I would like to comment that there needs to be a further consideration of the appropriateness review function in your new legislation. We need appropriateness review, and support the idea fully. The question facing local volunteers is this: after the HSA makes a finding about appropriateness or inappropriateness, then what? Where are the sanctions? We know that we do not have the authority or power to change inappropriate services. Who does? If no one does, then why should we volunteers bother being involved? We have jobs, families, and other things to do with our time.

Please make the time we donate to the health planning process worthwhile. Please finish the system you have begun to create. Let's see some action in health planning at the local and state levels, not just paper and talk.

Finally, I would like to emphasize the need to provide adequate funding to HSAs. You can't ask a man to be a combination of a wrestler, power weight lifter, long distance runner and mathematical genius, and then feed him a diet of soda crackers. This is especially true for the minimally funded rural HSAs. They have more travel costs, more time commitments, and all the same technical responsibilities as the biggest HSAs in the nation, but only a fraction of the budget. Our staffs have to be multi-talented wizards. But even wizards cannot make health systems plans and community changes on the budgets they have been given thus far.

We plead with you to make adequate appropriations--at least the sums asked for this morning by the Health Planning Association witnesses. And we hope the Secretary of HEW will understand that when your bill gives him discretion over 10% of the appropriation, he is expected to use that discretion to help rural HSAs do their job.

Gentlemen, thank you for your time, and thank you for a very good set of amendments. Please stick to your guns in the weeks ahead. We need a good, strong, and balanced bill. That's what we've got now. I hope we can keep it that way.

Mr. ROGERS. Thank you very much, Mr. Gilman. I would like to say that these points that you have brought up will be most helpful in determining these provisions.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. I just want to commend the gentleman on the work he is doing. I think he is a typical, good American citizen, very good, and when he says that he looks for live bodies there at his meetings, I know what he means. I think that is one of the difficulties we have so many times with organizations such as this.

Further, I want to compliment you on saying, "please, gentlemen, resist the pressure you are getting to change HSA structures yet again." I think you are right.

Mr. GILMAN. Lord, I hope I am right, because we fought the battle and the bloodletting in California that went on with the delineation of those lines. I would not want to see that transpire again. I think it would be supercounter-productive.

Mr. CARTER. Well, certainly I have enjoyed your testimony and I want to compliment you on your work, and I ask that you continue. Do not give up.

Thank you, Mr. Chairman.

Mr. GILMAN. I will try not to.

Mr. ROGERS. Thank you. We appreciate your presence here today.

Mr. GILMAN. Thank you.

Mr. ROGERS. The next witnesses will be Mr. David Everhart, who is president of the Northwestern Memorial Hospital, accompanied by Dr. John A. D. Cooper, who is president of the Association of American Medical Colleges.

I am delighted to welcome you gentlemen to the committee. Thank you for your patience.

Your statement will be made a part of the record in full [see p. 399], and you may proceed.

STATEMENT OF DAVID EVERHART, ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY JOHN A. D. COOPER, M.D., PRESIDENT

Mr. EVERHART. Thank you, Mr. Chairman.

I am Dave Everhart, chairman of the Council of Teaching Hospitals of the American Medical Colleges, and president of Northwestern Memorial Hospital in Chicago; and with me, as you have acknowledged, is John Cooper, who is president of the AAMC. We will dispense with the usual formalities, Mr. Chairman. We have submitted a written statement for the committee and for inclusion in the record.

In 1974, the AAMC submitted testimony to this same subcommittee endorsing major components of the bills that ultimately became Public Law 93–641. Since passage of the act, the AAMC and its members have supported its implementation. Last year, the AAMC supported a 1-year extension of the act and called for its more complete implementation to be a cornerstone of our Nation's hospital cost-containment policies.

Last March, the AAMC engaged the services of Gene Rubel, who is the former Acting Director of HEW's Bureau of Health Planning Resources and Development, to visit a number of our teaching hospitals, medical schools, and HSA executives to determine the current and the future implications of the implementation of 93–641 as it pertains to our academic medical centers around the country. Mr. Rubel very frankly reported that the issue drew some emotional responses and many described the planning process with words like "cumbersome," "time consuming," "frustrating," and "confusing." However, he also reported, in balance, that there was a general acceptance for the need and mandate for active participation in the effort.

The AAMC is pleased to find that H.R. 10460 proposes working within, and improving, the planning structures created in the past 3 to 4 years. In reviewing the bill's provisions, the association finds several amendments which are highly desireable: The expansion of certificate-of-need authority. The increased authorizations for Federal funding. The provisions of authority for carrying over funds from 1 year to the next. The recognition that individuals living and working in areas covered by different HSA's are interested in serving and supporting both agencies. And the addition of indirect providers of care to HSA governing boards. Each of these amendments would strengthen the existing legislation.

I think there is a personal point that I would like to make, and several of the witnesses this afternoon have made reference to it, and I want to make it because I believe it is a concern that is widely shared by a number of my professional colleagues who are involved with HSA's around the country. In a way, I make the point reluctantly because it could be misunderstood, and it addresses the question of the majority of consumers on HSA boards. I think that has caused some difficulty for providers who are attempting to comply with the planning laws. Some of these consumers are unfamiliar with our health care systems and their institutions, and the lack of that familiarity lengthens the process. We hope very much that the moneys included in the bill for better orientation and education of members of HSA's will meet your interests in maintaining community accountability and, at the same time, our concerns about having more informed decisionmakers in this process. Now, there are, however, some AMC concerns which are either not addressed, or only partially addressed, in the amendments, and we would like to speak to those. In discussing them and in making specific recommendations, we are attempting to further strengthen, and to refine, 93–641.

The National Health Planning Resources Development Act seeks, in part, to increase patient access to health services, and this is certainly a laudable objective. It should be remembered, however, that access to health services is also important for medical education and for biomedical research plans. To insure that health services continue to meet present health care needs and help develop future health resources, the AAMC recommends that this subcommittee develop and approve amendments to 93–641 which would explicitly recognize the importance of health services to health manpower education and to biomedical research.

First, the AAMC recommends that the act be amended to encourage proposals for the location and sponsorship of institutional health services to include the proposals' impact on the clinical needs of medical education and medical research programs. Proposals that are being considered for scarce health services in areas that involve one or more accredited medical schools must include evidence that the service, if approved, will be available and accessible to faculty, students, graduate medical trainees, and schools of medicine.

Second, if the health service area includes one or more accredited medical schools, we strongly recommend that the governing board and executive committee of the HSA be required to include the dean of at least one medical school as a voting member of that HSA board. Similarly, in States with one or more accredited medical schools, the AAMC recommends that the State Health Coordinating Council be required to include the dean of at least one medical school on its board.

Medical schools, faculties, and teaching hospitals serve today's patients as they develop the manpower and knowledge essential for tomorrow's health system. To accomplish these dual missions, health planning decisions of today must not undermine the resources development programs of medical schools and teaching hospitals. Section 1513 states that a health systems agency shall not review and approve or disapprove the proposed use of Federal funds for grants or contracts unless they are used to support the development of health resources intended for use in the health service area, or in the delivery of health services. Regulations implementing this portion of the law have not yet been promulgated, thus we are unclear of its ultimate effect. Moreover, the association is also unclear about the intent and effect of section 220(b) of 10460, an amendment which broadens, but does not clarify, the HSA's authority in this area.

Massachusetts has recently amended its certificate of need legislation to exempt from review medical education and/or research programs which are financially self-supporting or do not result in an increase in patient charge and do not increase the number of operating beds or the load of ambulatory services to an institution. We believe this is an excellent piece of legislation that clearly removes from the HSA review, medical education and research projects with only minor health service impact and the association strongly recommends a similar amendment to the health planning and resources development act.

It would be difficult to draft a suitable amendment for the broader range of impacts of Federal grants and contracts for medical education and research which do include substantial health service impacts. In lieu of such a difficult amendment, we recommend that the committee report accompanying any bill to amend the present health planning law include a clear statement of the congressional intent in this area. If this recommendation is acceptable, we agree to provide the fullest cooperation and assistance to your committee as you prepare such a statement.

Recently the AAMC has learned of instances where an HSA has established conditions of approval in reviewing requests for new services and equipment—that is, the hospital has been told by an HSA

that the hospital request to initiate service A would be approved only if the hospital also agreed to implement service B, another service sought by the HSA. The association views such conditions of approval as excessive uses of authority and urges this subcommittee to address this issue by adopting an amendment which provides that, except in the evaluation of clinically interdependent health services, such as cardiac cathertization, open heart surgery, HSA's are prohibited from conditioning the approval of a certificate of need application upon the providers agreement to develop one or more additional health services or programs.

In spite of HEW's recent publication of the revised planning guidelines—and I kind of hate to get into this in a way—the AAMC remains concerned about the function of such guidelines. In his January 18 press conference, Secretary Califano, in his prepared statement, said these national standards are to be used by local and State agencies in preparing their plans. The plans generally should be consistent with the guidelines within 1 year. It would appear that HEW sees little difference between guidelines and mandated standards. This is contrary to our understanding of the role of the planning guidelines and the association strongly recommends that any legislation renewing or extending 93–641 clearly and forcefully state that the HEW is to promulgate advisory guidelines, not mandatory guidelines.

In the 4 years since the National Health Planning and Resource Development Act was enacted, many of the organizations required by the act have been developed and have become operational. The structure is in place. If that structure is to be retained, strengthened and increasingly supported with adequate funding and technical assistance, the next few years should see the planning of planning replaced by health planning itself. In its next renewal, the health planning program should be evaluated on its performance as well as on its promise. For such a performance review to be objective and meaningful, criteria for assessing the program's accomplishments and shortcomings need to be established now. Otherwise, the same anecdotes and statistics may be used by program proponents and opponents as justification for terminating or continuing the program.

The Association of American Medical Colleges strongly recommends that any legislation extending or revising health planning be accompanied by a committee report detailing criteria which will be used to evaluate the program in its continuation. We will be pleased to work with members of this subcommittee and its staff to develop and evaluate such criteria for program performance.

Thank you, Mr. Chairman.

[Testimony resumes on p. 413.]

[Mr. Everhart's prepared statement follows:]

association of american medical colleges

TESTIMONY SUBMITTED ON
HEALTH PLANNING LEGISLATION

BY THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TO THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
U.S. HOUSE OF REPRESENTATIVES

January 31, 1978

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the renewal and revision of the National Health Planning and Resources Development Act of 1974. In addition to representing all of the nation's operating medical schools and sixty-three academic societies, the Association's Council of Teaching Hospitals includes 406 of the nation's major teaching hospitals. These Association members: educate the vast majority of American-trained physicians at both the undergraduate medical and graduate medical levels; conduct a substantial proportion of the nation's biomedical research; account for over sixteen percent of the admissions and approximately twenty percent of the ambulatory care services provided by non-Federal short-term hospitals; and provide a comprehensive range of patient services, including the most complex tertiary services. Because of this joint involvement in health resources development and health services delivery, the revision of the National Health Planning and Resources Development Act is of direct interest and a vital concern to the Association's members.

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For ease and clarity of presentation, this testimony is organized in three major sections. The first section reviews the AAMC's historical and continuing support for organized and integrated health planning. Section two reviews several health planning and resources development concerns of the Association and its members and suggests recommendations for clarifying and strengthening the planning program. The final section requests that this Subcommittee and its staff begin developing evaluation criteria for the performance of the health planning agencies so that future extensions or revisions of the planning act can be based on the documented successes and failures of the program.

General AAMC Positions

As a result of member experiences with health planning under regional medical programs, comprehensive health planning, and Hill-Burton legislation, the Association of American Medical Colleges, in 1974, determined that it was essential to have an effective and unified system of health planning on a national scale. In addition to drafting a legislative proposal which combined the planning and development aspects of RMP, CHP, and Hill-Burton, the AAMC submitted testimony to this Subcommittee endorsing major components of the bills that became P.L. 93-641.

Since passage of the health planning act, the AAMC and its members have supported implementation of the planning act by consulting with and advising HEW, state, and local agencies on its implementation; by reviewing and commenting on proposed HEW and planning agency regulations; and by participating as board and committee members on many HSAs and SHCCs. Last year, the AAMC supported a one year extension of the Act and called for its more complete implementation to be a cornerstone of our nation's hospital cost containment policies.

Upon reviewing H.R. 10460, the Association concludes that the nation was well served last year's extension of the health planning act which permitted a systematic review of the Act. Recognizing that this Subcommittee could have called for either a repeal or radical restructuring of P.L. 93-641, the AAMC is pleased to find that H.R. 10460 proposes working within and improving the planning structures created in the past three to four years.

In the past fourteen years, our nation has had four major health planning programs. Some of these have failed because they were poorly-financed, ill-staffed, or not given a chance to succeed. The Association strongly supports this Subcommittee's interest in permitting the current planning law to have an adequate opportunity to fulfill its promise by strengthening and improving existing planning mechanisms.

In reviewing the specific provisions of H.R. 10460, the Association finds several amendments which are highly desirable and supported by the AAMC: the expansion of Certificate of Need authorities, the increased authorizations for Federal funding, the provision of authority for carrying over funds from one year to the next, the longer certification of HSAs, and the recognition that individuals living and working in areas covered by different HSAs are interested in serving and supporting both agencies. Each of these amendments would strengthen the existing legislation. There are, however, some AAMC concerns which are either not addressed or are only partially addressed by the amendments of H.R. 10460. In discussing these concerns and in making specific recommendations, the AAMC is attempting to further strengthen and refine P.L. 93-641.

Specific AAMC Recommendations

Access to Health Services

The National Health Planning and Resources Development Act seeks, in part, to increase patient access to health services. This is a laudable objective.

It should be remembered, however, that access to health services is also important for medical education and biomedical research programs. Patient care, medical education, and biomedical research programs are mutually interdependent -- each requires and serves the other two as a resource. Because of this interdependence, the health services provided today also help develop health resources for tomorrow.

To ensure that health services continue to meet present health care needs and help develop future health resources, the AAMC recommends that this Subcommittee develop and approve an amendment to P.L. 93-641 which would explicitly recognize the importance of health services to health manpower education and biomedical research. The AAMC recommends that the Act be amended to encourage proposals for the location and sponsorship of institutional health services to include the proposal's impact on the clinical needs of medical education and medical research programs. Given that a health service area, region, or state needs a particular health service, health planning and resource development objectives can be most cost effectively served by encouraging a health service, when appropriate, to simultaneously serve as a medical care, medical education and medical research resource.

To help ensure that separate independent services are not sought exclusively for patient care, education, or research uses, the Association of American Medical Colleges recommends that the amendment further provide that, if a health service area includes one or more accredited schools of medicine, applications for approval of health care services, which are not to be readily approved for all institutional providers, must include evidence that the service, if approved, will be available and accessible to faculty, students, and graduate medical trainees of the school(s) of medicine.

Regionalizing health care services so that they may be provided at high quality and reasonable cost is an appropriate national goal. This goal, however, will be ineffectively served if high cost services provided to relatively small numbers of patients are developed in excess of patient requirements because some of the settings for these services do not make them available to meet medical education needs. All services need not support medical education programs, but enough services should support or provide access to medical education programs so that the educational system is not required to develop patient services primarily for physician education.

Developing Future Health Resources

Medical schools, medical faculties, and teaching hospitals serve today's patients as they develop the manpower and knowledge essential for tomorrow's health care system. To accomplish these dual missions, health planning decisions of today must not undermine the resources development programs of medical schools and teaching hospitals. Section 1513 (c)(1)(B) of P.L. 93-641 states that "A health systems agency shall not review and approve or disapprove the proposed use within its area of Federal funds appropriated for grants or contracts under Title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services." Regulations implementing this portion of the law have not been promulgated. Thus, the AAMC is unclear of its ultimate effect. Moreover, the Association is also unclear about the intent and effect of Section 220 (b) of H.R. 10460, an amendment which broadens, but does not clarify, the HSA's authority in this area.

The Health Professions Educational Assistance Act of 1976, P.L. 94-484 establishes programs and authorizes funds to encourage medical schools and

teaching hospitals to expand family practice, general internal medicine, and general pediatrics training programs and to improve and develop ambulatory care services. The AAMC and its members are unclear as to whether the planning law at present, or as proposed, requires HSA's to review and approve grants sought under these incentive programs. Similarly, the AAMC is unclear as to whether this Subcommittee intends, by the proposed amendment, to require review and approval by the HSA of NIH grants for purposes such as clinical trials and diagnostic-specific research centers.

The nation's resources development and long-term health service needs will not be served best by requiring HSA's to regulate the nationwide resource development programs of Federal agencies which have little or no impact on the delivery of health services. In this situation, the AAMC recommends an amendment exempting some grants and contracts from review, recommends including in the Committee Report essential clarifying language on Congressional intent, and offers to discuss this matter further with this Subcommittee and its staff.

Massachusetts has recently amended its certificate of need legislation to exempt from review medical education and/or research program (projects) which are financially self supporting, do not result in an increase in patient charges, and do not increase the number of operating beds or the load of ambulatory services of an institution. The AAMC believes this is an excellent piece of legislation that clearly removes from HSA review medical education and research projects with only minor health service impacts, and the Association strongly recommends a similar amendment for the Health Planning and Resources Development Act.

It would be difficult to draft a suitable amendment for the broader range of impacts of Federal grants and contracts for medical education and research which do include substantial health service impacts. In lieu of

such a difficult amendment the AAMC recommends that the Committee Report accompanying any bill to amend the present health planning law include a clear statement of the Congressional intent in this area. If this recommendation is acceptable, the AAMC agrees to provide its fullest cooperation and assistance to Committee members and staff as they prepare such a statement.

Introducing New Health Services

In the past few years, the CT scanner has received significant attention from health providers, planners, third party payors, and legislators. The CT scanner will not be the last new expensive technology; others will be developed. The health planning process can be used to thwart the introduction of such innovations or the process can be used to regulate their introduction.

As new technologies are created and introduced, HSAs will be confronted with certificate of need or service requests for which they have not established guidelines. A "Catch 22" situation could result if HSA's will not permit at least the limited introduction of new technologies, for unless the technologies are introduced there will be no experience on which to base planning guidelines and decisions. Innovations must be introduced, used, and evaluated to determine their usefulness, and HSAs must have sufficient latitude to permit such innovations in the absence of documented guidelines. Therefore, the AAMC recommends that health systems and state health plans be required to include provisions for the introduction of new medical devices and innovations which must be deployed in limited numbers to evaluate their clinical usefulness and cost effectiveness. Moreover, the AAMC recommends that the Secretary of HEW be required to perform or commission studies on approaches to the introduction, deployment, and cost-benefit analysis of

expensive new medical technology.

Regionalization and Tertiary Care Services

The AAMC has supported and continues to support the regionalization, or concentration, of health services which are of high cost or relatively low demand. The Association is, therefore, pleased with and strongly supports the provisions of H.R. 10460 which would expand certificate of need requirements to include all providers regardless of setting. The present effectiveness of health planning agencies is severely handicapped by the exclusion of non-institutional services from the mandated certificate of need process. For example, in some areas where hospitals and health planners have worked cooperatively to rationally introduce CT scanners, the cost savings to the community have been eliminated by physicians acquiring scanners in office-based settings not subject to review. This Subcommittee is encouraged to eliminate this double standard and health planning loophole.

Also, the AAMC has learned of instances where an HSA has established "conditions of approval" in reviewing requests for new services and equipment. That is, the hospital has been told by the HSA that the hospital request to initiate service A would only be approved if the hospital also agreed to implement service B, another service sought by the HSA. The Association views such "conditions of approval" as excessive uses of authority and urges this Subcommittee to address this issue by adopting an amendment which provides that, except in the evaluation of clinically interdependent health services (e.g., cardiac catheterization and open heart surgery), HSAs are prohibited from conditioning the approval of a certificate of need application upon the provider's agreement to develop one or more additional health services or programs.

Beyond the principle involved in eliminating "conditions of approval," there are practical considerations which support the same recommendation. Hospitals have limited amounts of long-term and working capital. The capital available may support adequately the development of service A but not services A and B. In this circumstance, and given that HSAs have little long-term capital to use in assisting the hospital, an approval that requires undertaking B to do A may mean that the hospital can do neither A nor B. This is a most undesirable outcome, and its cause should be eliminated.

Planning Guidelines

In the past few months, health planning has received new visibility as a consequence of the debate over HEW's proposed health planning guidelines. In the AAMC's view, the debate contains two major issues: one focuses on the development and specification of the quantitative components of the guidelines; the other focuses on the authority HEW has, under the law, to enforce or require compliance with the guidelines. This latter issue is of the utmost seriousness. It requires a Congressional solution.

In his January 18th press conference, Secretary Califano, in his prepared statement, said: "These national standards are to be used by local and state agencies in preparing their plans. The plans, generally, should be made consistent with the guidelines within one year." It would appear that HEW sees little difference between guidelines and mandated standards. This is contrary to the AAMC's understanding of the role of planning guidelines, and the Association strongly recommends that any legislation renewing or extending P.L. 93-641 clearly and forcefully state that HEW is to promulgate advisory guidelines not mandatory standards. Such a statement of Congressional intent would be significantly strengthened by removing from Section 1513 (b)(2)(C) the present language which states that health service plans are to be "consistent"

with national guidelines. The Secretary is relying on this phrase to justify mandated national standards.

The original intent of P.L. 93-641, as understood by the AAMC was to develop a national health planning program from the bottom up, i.e., from local to state to national areas. This intent is being undermined by HEW's insistence on imposing rigid national standards requiring local compliance. Amendments and Congressional reports should clearly and forcefully re-establish that the national planning program is to be based on local initiative and responsibility.

The AAMC is also concerned about the juxtaposition of the health planning guidelines and the Administration's proposal for controlling hospital revenues and capital. Under the utilization standards set forth in the proposed guidelines, many low volume hospital services, such as obstetrics, cardiac catheterization and open heart surgery, would have to close and the implementation of revenue limitations as proposed by the Administration would provide an economic incentive for other such closures. The changing referral patterns for such services would bring the patients who formerly received care from these hospital programs to tertiary care centers -- academic medical centers and teaching hospitals -- for the services. Given any imposition of revenue caps and the fact that services addressed by the guidelines are mostly of a high-cost nature, the tertiary care referral centers may be placed in a position where their revenue capacity will be inadequate to accept these additional patients. The net impact of this desirable regionalization of high technology services could mean drastic reductions in their availability as hospitals with inadequately utilized services drop them and as inadequately reimbursed medical centers find they are unable to support added tertiary care services. This incomplete regionalization would leave many patients who need

tertiary care services in the extremely difficult, if not desperate, situation of trying to obtain services in short supply.

Service availability and hospital cost containment are both desirable objectives. In some situations, however, they are mutually exclusive objectives. Because H.R. 10460 would add cost containment to the objectives of health planning, this Subcommittee is urged to include in the Committee Report accompanying any bill to extend or modify present health planning programs a careful and clear statement of Congressional priorities when cost containment threatens to reduce the availability of or access to necessary health services.

Membership on Governing Boards

In a planning process requiring initiative and responsibility at local and state levels, it is important that governing boards broadly represent the community, including its health-related interests. Representation is especially important for medical education institutions. First, as discussed in an earlier section of this testimony, medical education programs rely on and contribute to health service programs. Including a representative from a medical school would help ensure that these interdependencies were recognized and considered in planning decisions. Secondly, as evidenced by health manpower legislation, medical education is increasingly viewed as a national resource. Capitation payments, capitation requirements, and Federal grant incentive programs all demonstrate the national character of medical education. Given the "bottoms up" character of health planning and the increasingly "top down" character of medical manpower development, it is important that planning agencies include on their governing boards individuals who can bring to the board's attention national initiatives requiring local consideration. Thirdly, the medical school is in a unique position to represent health

manpower education generally, for it is the medical school faculty that admits the patients who are involved in the training and education of all health science students. Under the present health planning law, HSA governing bodies must include providers who represent "health professional schools." For the reasons stated above, if a health service area includes one or more accredited medical schools, the AAMC strongly recommends that the governing board and executive committee of the HSA be required to include the Dean of at least one medical school as a voting member. Similarly at the state level, in states with one or more accredited medical schools, the AAMC recommends that the SHCC be required to include the Dean of at least one medical school as a voting member.

Present requirements for the composition of HSA governing boards also mandate membership for providers who represent health care institutions; however, these governing boards do not have to include direct representatives from hospitals. This is a serious omission. The Health Planning and Resources Development Act relies heavily upon hospitals to achieve its goals. Hospitals are major sources of ambulatory care, emergency services, and definitive inpatient care. Tertiary care/teaching hospitals, moreover, are different from the nation's other hospitals because they also provide: regionalized, tertiary care services to significant numbers of referred patients; medical education programs from undergraduate clinical clerkships to post-graduate fellowships; and the environment for developing and evaluating new medical treatments and techniques. Because of the organizational complexity of the multi-product tertiary care/teaching hospital, it is crucial that the internal dynamics and external interrelationship of these hospitals be specifically included in HSA deliberations and planning. Therefore, the AAMC recommends that HSA governing board and SHCC requirements be changed to

require that at least one member of each body be the chief executive officer of a short-term, general, tertiary care/referral hospital.

Mandated Capital Expenditures

Each year hospitals make sizable capital expenditures in order to comply with mandatory changes required by various codes, standards, and regulations. Some of these construction and modernization programs require certificate of need approval, others do not. In any case, the magnitude of these expenditures and their impacts on hospital costs is not well documented. If the health planning program is to have a cost containment objective, as proposed in H.R. 10460, adequate information is needed on hospital expenditures for mandated capital improvements to ensure that capital planning adequately includes changes in present facilities. Therefore, the AAMC recommends amending H.R. 10460 to require the Secretary of HEW to undertake or sponsor expenditure and cost-benefit studies of mandated hospital projects resulting from externally imposed life safety, and building codes.

A Concluding Concern

In the four years since the National Health Planning and Resources Development Act was enacted, many of the organizations required by the Act have been developed and become operational. The structure is in place. If that structure is to be retained, strengthened, and increasingly supported with adequate funding and technical assistance, the next few years should see the planning of planning replaced by health planning itself. At its next renewal, the health planning program should be evaluated on its performance as well as its promise. For such a performance review to be objective and meaningful, criteria for assessing the program's accomplishments and shortcomings need to be established now. Otherwise, the same anecdotes and statistics may be used by program proponents and opponents as justification

for terminating or continuing the program.

The Association of American Medical Colleges recommends that any legislation extending or revising health planning be accompanied by a Committee Report detailing criteria which will be used to evaluate the program for its continuation. The AAMC would be pleased to work with members of this Subcommittee and its staff to develop and evaluate such criteria for program performance.

Mr. ROGERS. Thank you very much, Mr. Everhart.

I still think that people do not understand that the Secretary of HEW, even though he calls them standards and says that people should adhere to them, the authority remains with HSA. The Secretary does not approve or disapprove any plan the HSA makes. They make their own plan. The guidelines are simply guidelines.

Now, the exceptions are in those broad areas so that the HSA's can adjust them as necessary. So the basic judgment is the HSA's.

I think that this is clear when you look at the process. The Secretary sets, as a national goal, these guidelines. We hope that people will work toward them, and it is the intent that they would. But the HSA makes its own plan and uses guidelines simply as guidelines.

Mr. EVERHART. You clarified that very well for——

Mr. ROGERS. I think that is true, and if there is any problem, we will make it clear.

Dr. COOPER. I think you would give a lot of help to those who are anxious about this by merely putting the statement in that this is, indeed—it would be much more helpful if these were called national goals, as you and the committee apparently believe they should be—rather than either standards or guidelines, and that would sort of remove the semantic problems of differences of statements which different people are interpreting in different ways.

Mr. ROGERS. I think it is true. I do not know if that would lessen the intent that we do want people to try, where possible, to make progress in the direction of the goals, and that is my concern about changing too much. That then they say, well, the guidelines do not mean anything.

Well, they are goals, and hopefully HSA's will begin to reach them. But if there is a reason not to have those applied in the area, that is the judgment for the HSA.

I must say that the AAMC has been most helpful to the committee during the entire process of this legislation, has been supportive, and your recommendations will be given due weight. It would be helpful to have specific language, I think, to carry out your suggestions [see p. 418].

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Certainly, I want to compliment you on your presentation. Really, I feel that you deserve the representation that you want on HSA boards. However, it is my feeling, and I believe that you would agree with it, that technology is changing every day and we get more exotic equipment all the time, and the trial ground, the proving grounds, are in the medical schools, and I do not know whether our HSA's, in some cases, should have the right to tell you what to use or what not to use.

I personally would like to exempt medical schools from some of these provisions so that you could be innovative. I do not think we want to put a cap on your efforts, accomplishments and inventions for the good of mankind.

Mr. EVERHART. Well, I think there would be general agreement with that. I was assuming in our statement—we were referring to teaching hospitals as contrasted to the separate body known as the medical school.

Mr. CARTER. Of course, in your teaching hospitals——

Mr. ROGERS. Would the gentleman yield?

Mr. CARTER. Yes, sir.

Mr. ROGERS. Are not many hospitals, teaching hospitals?

Mr. CARTER. Sure they are.

Mr. EVERHART. I would hope that most hospitals would be teaching hospitals, Mr. Chairman.

Mr. ROGERS. You would not want us to exempt them all, I take it?

Mr. EVERHART. No; I do not think we are requesting exemption as teaching hospitals. That is not the point of our testimony.

Mr. ROGERS. All right.

Mr. CARTER. I am sure that the gentleman would not——

Mr. EVERHART. That would be nice, if you would like to talk about it. I assume that there is not much practical value in this.

Mr. CARTER. But doctor, you would want enough leeway to use different types of new equipment, and you would want to have sufficient availability of CAT scanners, and so on?

Mr. EVERHART. Dr. Carter, I think that is the essence of the concern of the 406 hospitals that I am representing. I think there has to be leeway and some flexibility in terms of particularly the development of new technologies and new procedures, hopefully——

Mr. CARTER. And teaching.

Mr. EVERHART. And teaching. That is part of the reason, I guess, that there is a concern that we have some access to the HSA phenomena so that this important segment of service that teaching hospitals do, in fact, provide, which is education, can also be interpreted as an important part of the product that a teaching hospital produces.

Mr. CARTER. Yes, sir. We would all like to put a cap on the rate of increase of hospital costs, but none of us wants to put a cap on innovation or invention of new technology to help mankind. And I do not want medical schools to ever be so constrained.

If you see such constraints, then I am sure that the chairman would like to know, and so would I.

Mr. EVERHART. Thank you.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. I think it might be helpful if you could get for us the information on how many representatives of a teaching hospital or the medical schools are on HSA's. Would that be possible?

Mr. EVERHART. I am not sure. Do we have that information? If not, we could certainly find it for you. I think it is important, too, where they have very large boards and where most of the work is done by executive committee, that that is also an important area.

I think that having these people on HSA's where they exist would help the HSA understand how a local agency, interested mostly in the health care and the services delivered to the population which they serve, fits into the national requirements for research and the development of manpower.

This has been one of the troubles that has been found in Canada, where there are provincial and national interrelationships on planning and so on. It is very difficult for an HSA, looking at its own needs, to really give due consideration often as to how that particular institution fits into the national scene. And we think at least by having

a representative on there, he or she can help interpret to them what the importance of these various activities that are going on that may not be as related to the local situation as some other activities that HSA's are considering, but on the national scene, are extremely important to the health of the Nation.

That is why we think it is important to have this line of input.

Mr. CARTER. By the way, is the County Hospital of Contagious Diseases still down on South California, or have you moved it long since?

Mr. EVERHART. In Chicago?

Mr. CARTER. Yes, sir.

Mr. EVERHART. I believe sir, that has been closed now.

Mr. CARTER. Archibald Hallen used to be the Dean there years ago. He was their chief physician, anyway.

Have you considered any changes in the medical school curriculum which might assist physicians in taking part in the health planning system.

Mr. EVERHART. I am sorry, sir?

Mr. CARTER. Have you considered any changes in the medical school curriculum which might assist physicians in taking part in the health planning system?

Mr. EVERHART. I do not know that there are any national figures on that. I am aware of what has happened at Northwestern and its curriculum, and there has been added, in the last year or two, an opportunity for me as the chief executive officer of the hospital to spend some time, several sessions, with freshmen medical students orienting them to the facts of life and that they are, in fact, coming into a system where costs and cost constraints are an important consideration.

Mr. CARTER. Yes, sir.

Mr. EVERHART. We certainly emphasize this at the level of graduate medical education. The interns and residents of our institutions I think are becoming much more conscious of the cost of the care that they are prescribing and I would hope that our medical centers across the country are, in fact, responding positively to this thing. I think they are.

Mr. CARTER. Thank you, sir.

Thank you, Dr. Cooper.

Mr. ROGERS. Would you let us know how many graduate schools have a course on cost containment?

Mr. EVERHART. I suspect that there are no schools that have a full curriculum. On the other hand, I suspect that most of them have some session on this as part of another——

Mr. ROGERS. Because we do want to try to encourage that.

Dr. COOPER. You know, we have tried—we think it is very important on the cost containment part to have the students involved very early in their own patients and looking at PSRO activities, cost containment and quality of care as well [see p. 422].

We have been trying for over 4 years—I think I have told you this on previous occasions—to get some support out of HEW, to get such programs instituted in the medical schools, but we have been unsuccessful.

Now, we have published, in the Journal of Medical Education, where we had a planning meeting to get this thing organized, papers

of schools that are doing this. But we agree with you. If you cannot get the students, at that point in their life, to understand and appreciate cost containment and the whole planning business, it is going to be much more difficult for them to be adequately and properly involved later.

Now let me say that we have had great difficulty in getting support to promote that.

Mr. CARTER. I just think that probably that in terms of the counselling of which you spoke, a specific amount of that with case examination would be enough, rather than for us to mandate a course in it.

Mr. EVERHART. Well, as you know, Dr. Carter, the sensitivities of a curriculum and a medical school are immense, and who is going to get, and how many hours and this kind of thing. It would be very interesting to try to work this in, however.

Mr. ROGERS. As I recall, we provide incentives for the colleges—authorized $1 million—to start such courses. In the cost containment legislation which this Committee has approved but has not yet passed we have $1 million to encourage that.

But I would hope that the schools would feel that this is a subject of sufficient importance that they would move on their own without waiting for a specific monetary encouragement.

Dr. COOPER. Really, what we need is not the money to support the program so much in the schools—that is one of the problems—but in setting up, as we have done with the National Heart and Lung Institute, objectives to be achieved in a medical school vis-a-vis hypertension.

We need to set up objectives to be achieved in this particular area, and to get those kinds of things together and to get people's time and effort devoted to this when they are overly busy with everything else, I think needs a little of this kind of support. It is something that I think will push this along much more rapidly than if it is just allowed to do it itself.

We have talked about this. We have had sessions on this in our meetings. As a matter of fact, our whole next annual meeting will be on national health planning and the policies, and so on.

But it does need some starting, some seeding of this function to get it to spread rapidly.

Mr. ROGERS. Well, we will try, and I would hope that you would let us know and make an inquiry of your universities how many have, or are planning, cost-containment courses. I think that would be helpful for us if you could do that for us.

Thank you so much.

Your testimony has been helpful to the committee. Thank you for being with us today.

Mr. EVERHART. Thank you.

Dr. COOPER. Thank you.

[Testimony resumes on p. 424.]

[The following material was received for the record:]

aamc association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

February 6, 1978

202: 466-5175

Honorable Paul G. Rogers
Chairman, Subcommittee on Health
and the Environment
Committee on Interstate and Foreign
Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Rogers:

As you requested at the January 31st hearing before the Subcommittee on Health and the Environment, the attached document specifies proposed language for the amendments which the AAMC recommends be made in the National Health Planning and Resources Development Act. Suggested Committee Report language discussing Congressional intent for HSA review of medical education and research contracts and grants with impacts on institutional health services will be furnished to you as soon as it is complete.

In questioning following the Association's testimony, you expressed interest in knowing the number of medical school deans and teaching hospital executives on HSA governing boards and SHCCs. You also were interested in medical school curriculum developments in the teaching of health economics and health planning. Appropriate data for these concerns will be collected shortly and furnished to you at the earliest possible date.

As your review of health planning legislation continues, the Association would be pleased to provide any additional assistance it could to you, the Subcommittee, or its staff.

Sincerely,

John A. D. Cooper, M.D.

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

Legislative Language
Recommended for
H.R. 10460

Access to Health Services

Objective: to encourage proposals for the location and sponsorship of institutional health services to include the proposal's impact on the clinical needs of medical education and medical research programs.

recommended language:

Section 1532 (c)(6) is amended by inserting "; the impact of such services on the clinical needs of health resource development programs (including health manpower education and medical research);" after the phrase "provision of such services."

Objective: to provide medical schools with access to approved clinical services and facilities.

recommended language:

Section 1532 (c) is amended (1) by redesignating subparagraph (8) as subparagraph (9), (2) by redesignating subparagraph (9) as subparagraph (10), and (3) by inserting the following new subparagaph:

"(8) In the case of new health services or health services available in a limited number of institutions, evidence that the service, if approved, will be available to faculty, students, and graduate medical trainees of accredited schools of medicine located in the health services area or state."

Developing Future Health Resources

Objective: to exclude from HSA review and approval health manpower education and biomedical research contracts and grants with no sigificant impact on the delivery of health services.

recommended language:

Section 1513 (e)(1) is amended (1) by inserting "or (C)"after the phrase "subparagraph (B)" in subparagraph (A), (2) by redesignating subparagraph (B) as subparagraph (C), and by inserting the following new subparagraph:

"(B) A health systems agency shall not review and approve or disapprove the proposed use of any contracts or grants for medical education and/or medical research programs which (i) are financially self supporting, (ii) do not result in an increase in patient charges, and (iii) do not increase the number of operating beds or the load of ambulatory services of an institution."

Introducing New Health Services

Objective: to permit the limited introduction of new technologies not addressed in the HSP, AIP, or state plans.

recommended language:

Section 1532 (c) is amended by inserting the following new subparagraph:

"(11) In the case of new diagnostic and treatment technologies for which planning guidelines have not been developed because of inadequate evaluation of their effectiveness or appropriate utilization, Health Service Agencies with the concurrence of their State Health Coordinated Council may approve requests

for a limited number of such new technologies prior to the development of planning guidelines."

Regionalization and Tertiary Care Services

Objective: prohibiting HSAs from conditioning the approval of a certificate of need upon the provider's agreement to develop one or more additional health services.

recommended language:

Section 1532 is amended by adding a new subsection as follows:

"(d) Criteria required by subsection (a) for health systems agency and state agency review shall not include considerations of the applicant's interest, willingness, or promise to develop one or more services not included in the proposal under review."

Planning Guidelines

Objective: to ensure health planning guidelines are promulgated as advisory guidelines not mandatory standards.

recommended language:

Section 1513 (b)(2)(C) is amended by deleting "and is consistent with" following "account

Governing Board Membership

Objective: to require the inclusion of at least one Dean, in areas with one or more medical schools, and one chief executive officer of a tertiary care/referral hospital.

recommended language:

Section 1512 (b)(3)(c)(iii) is amended by adding the following subclauses:

"(VI) if the health systems agency serves an area which includes one or more accredited schools of medicine, include, as a voting member, the Dean of at least one of the area's medical schools.

(VII) include as a voting member the chief executive officer of at least one tertiary care/referral hospital located in the area."

Section 1524 (b)(1) is amended by inserting:

"(E) if the state includes one or more accredited schools of medicine, the SHCC shall include as an appointed, voting member the Dean of at least one accredited medical school.

(F) the SHCC shall include as a voting member the chief executive officer of at least one tertiary care/referral hospital."

aamc association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

202: 466-5175

February 28, 1978

The Honorable Paul G. Rogers
Chairman
Subcommittee on Health and the Environment
Committee on Interstate & Foreign Commerce
U.S. House of Representatives
Washington, D.C.

Dear Mr. Rogers:

Following the AAMC testimony on H.R. 10460, the bill to revise and renew the National Health Planning and Resources Development Act (P.L. 93-641), you requested information on the number of schools offering courses in health economics. I am happy to provide you with the available information.

In the Association's annual curriculum survey respondents are asked to indicate by "yes" or "no" whether or not they have courses in Health Care Delivery and PSRO/Peer Review. The data from the last several years is noted below:

Year	Health Care Delivery		PSRO/Peer Review	
	#	%	#	%
1974-75	82	70.1	Not available	
1975-76	74	63.2	35	29.9
1976-77	75	64.7	23	19.8
1977-78	80	67.2	24	20.2

While this information does not answer your question precisely, it is safe to assume, I think, that health economics instruction will be incorporated into these two areas.

It may be of further interest to you that for the past two years the AAMC has tried, without success, to obtain DHEW support for a program to facilitate the introduction of quality assurance methodologies within the curriculum of undergraduate medical education. Over a year ago we were encouraged by the receipt of private funding from the National Fund for Medical Education which has allowed us to conduct two pilot workshops on this subject, the second of which is scheduled for early April, 1978.

This effort has evoked considerable interest nationally. Those institutions which have used the workshop process to facilitate the interchange of ideas and to strengthen their program development are also interested in expanding these education concepts into the area of health care cost containment. Such an extension from quality assurance to cost containment/management strategies is of course both logical and timely. The AAMC would be most anxious to assist in the coordination and extension of such an effort if we could identify a source of financial assistance within the DHEW. Your thoughts on this matter would be appreciated.

I hope that the information we are providing will be useful to you. If you have any further questions please feel free to contact me directly.

Sincerely,

John A.D. Cooper, M.D.

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Mr. ROGERS. The next panel will be composed of Roger L. Smith, councilman, ward III and chairman of Mid-America Regional Council; and also Mr. Arthur Webb, who is the executive director of the New York State Health Planning Commission.

Mr. Webb and Councilman Smith. Are they present?

Thank you. If you would take a place at the table, we welcome you gentlemen to the committee. We appreciate your patience in being here with us so long. Your statements will be made a part of the record in full, if you could highlight for us the points that you think are most important.

STATEMENTS OF ARTHUR Y. WEBB, ON BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS; AND ROGER L. SMITH, ON BEHALF OF THE NATIONAL ASSOCIATION OF REGIONAL COUNCILS, ACCOMPANIED BY PETER LEVY, EXECUTIVE DIRECTOR, MID-AMERICA REGIONAL COUNCIL

Mr. WEBB. Thank you, Mr. Chairman and members of the committee. I am Arthur Webb, executive director of the New York State Health Planning Commission. Today I am representing the Association of State and Territorial Health Officials.

I will make my remarks brief, since you have my prepared testimony [see p. 427].

I think it is appropriate, Mr. Chairman and members, to point out first on that I think these amendments go a long way in trying to rectify and clarify much of the confusion with which we at the State level have had to deal over the last 2 years.

I think it is also appropriate to lay out about four principles that will indicate to you why these amendments are important to us.

First: We believe that the planning pact can be a vehicle to promote rationality, but that must develop a process that is practical and is relevant to the job at hand.

Second: We maintain that the act must include State government as a full partner, so that the leadership role which is vitally needed in this health planning area may be assumed.

State government must believe in this act, and commit its full authority and resources to it in order to insure its success.

Third: We believe that the next step in the evolution of planning should be the integration of the planning processes at all levels and the development of uniformity and consistency throughout the system. While this is essential, ASTHO strongly believes that and the Federal Government must recognize in the act the tremendous differences among the States, in their political, traditional, and historical perspectives, their problems and their individual approaches to planning.

Fourth: We believe that there should be minimum disruption right now in terms of the planning process. We should now be in the process of building and clarifying the roles and responsibilities. The health planning process has begun to flow, and we are beginning to see the fruits of our labor.

The amendments, as I stated earlier, are a step in the right direction, in the recognition of present confusion. Many of the amend-

ments do strengthen the State's hand—for instance, the appointment of the chairman, by the Governor, and setting and stating the statewide priorities by the SHPDA.

We also endorse the strengthening of the certificate-of-need laws in terms of coverage of medical equipment, and the setting of the capital limit in terms of that medical equipment.

We do see some problems, sir, in terms of the HMO exclusion. We believe that these are an essential part of the overall health care delivery system and that they should be part of the certificate-of-need process. But, we also believe that they can be streamlined in order to further allow their expansion and facilitate their development.

We also support the provision which extends the certificate-of-need application process from 90 days to 1 year. We believe in the intent of this, which I assume, is to allow for comparative analysis and batching. We do, at the same time, think the States should have some control over its limits. We are pursuing that in New York State.

Probably one of the most confusing parts of the health planning act concerns the use of formula grants, with regard to who has approval, et cetera. We believe that, even with the committee's amendments, problems will remain.

We believe that the State governments should have the approval over the use of these funds so that they can channel these critical, but limited resources, to areas where they are most needed.

We believe that title XVI is a major step forward and a very positive area for further development, because it begins to target those funds needed for modernization, renovation, and development of ambulatory care programs.

I would like to mention, at this time something that is of major importance to all of us, and of primary importance in New York State. At this point, I am speaking from New York State experience and that of the other large States who are represented by ASTHO. I am referring to excess capacity.

We absolutely believe that it is a primary problem, and yet it is unfortunate that it often occurs in areas where, in fact, the population is medically underserved. A great deal of our excess capacity happens to be in our inner cities. What are the solutions to this problem?

What should our policy be? We believe our policy must be sensitive to access, quality of care, alternate uses, manpower, referral patterns, and financial issues, such as debt. Secondly, we must have the authority for decertification. We, in New York State, have passed, 2 years ago, legislation which mandates authority to decertify according to planning requirements.

The next step should be to tighten up the certificate-of-need process related to capital investment and formation in each State, coupling the State having control, with the advice of the SHCC and the HSA's.

The Federal Government must participate in this by setting some broad guidelines and standards, and it must also support the studies necessary to fully understand the use of capital and its formation related to health care delivery.

We must determine how much capital is enough, and the extent of its impact on operating costs. We must understand the principles of

depreciation and how that has been used to form capital that has, in our belief, generated excess capacity.

The appropriateness review section of your amendments does address kinds of sanctions necessary to possibly enforce decertification. But, we believe that we can go further.

It is unfortunate that we must have sanctions in order to correct some abuses in the system, but we believe the appropriateness review is the first step.

Sir, that concludes my remarks.

[Mr. Webb's prepared statement follows:]

TESTIMONY ON H.R. 10460
BY
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
PRESENTED BY

ARTHUR Y. WEBB
EXECUTIVE DIRECTOR
NYS HEALTH PLANNING COMMISSION

Mister Chairman, members of the Committee, I am Arthur Y. Webb, Executive Director of the New York State Health Planning Commission, and I am here today to testify on behalf of the Association of State and Territorial Health Officials, commonly referred to as ASTHO.

In the several years that have passed since the enactment of the National Health Planning and Resources Development Act, we in state health planning agencies have had an opportunity to evaluate its strengths and its weaknesses. We remain convinced that this law can be the vehicle by which this nation can achieve a more effective, economical use of its health resources, and through which it can promote the development of locally sensitive health programs and facilities.

Nonetheless, experience to date has established that the law itself is highly complex, that it has not had the desired effect of containing the upward spiral of health care costs, and that it does not provide the flexibility necessary to encompass the valuable initiatives many states have undertaken in the field of health planning and development. The State is the proper level for plan integration and implementation. Clearly, changes are in order if we are to attain the laudable goal of this legislation: equal access to quality health care at a reasonable cost.

Thus, Mr. Chairman, we applaud your efforts to introduce amendments designed to recognize the concerns expressed by many responsible voices in the fields of health and health care, this organization among them.

We will work to achieve the goal of a uniform and consistent planning process that is relevant to the job at hand of setting of priorities and the rational allocation of resources to meet health needs. Our examination of these amendments convinces us that they represent definite progress, advancing the goal of uniformity and consistency, and in terms of recognizing the important role of state governments in planning for the health needs of their citizens.

In order for the Planning Act to have an effect on cost, accessibility and the involvement of health status, state government must bring to bear its full authority and resources to accomplish these objectives. Therefore, state government must believe and have a commitment to this process for success. If the federal government attempts to establish national priorities, it must recognize at the same time the tremendous differences among the states in their historical, political circumstances, problems and individual approaches to planning. ASTHO recognizes that public accountability is essential for governmental funds, that ASTHO is committed to protect the safeguards necessary for the use of public funds.

It is our overall impression that these amendments will provide the means by which the various states may plan to develop a national health care system, one that is efficient and responsive and not the non-system with which we have had to cope for so many years.

We welcome this opportunity to comment on specific areas covered by the proposed amendments.

We are especially pleased that the thrust of this legislation is to give the states greater participation in the health planning process, as well as greater control of the instruments of that process, most notably gubernatorial appointment of the chairmen of the State Health Coordinating

Councils (SHCC).

In general, however, we believe the federal statute should be amended and administered in a way which will allow the Governor to approve and manage a health policy planning system which is consistent with state law and custom. The federal statute should, in our view, recognize the Governor's constitutional responsibility to act on behalf of the state which he or she governs. All final regulatory decisions, approval of health plans and expenditure of public funds for this purpose should remain the responsibility of the Governor.

Granting the State Health Planning and Development Agency the authority to set statewide priorities will insure that state government goals are being addressed, but the Governor should have approval over the State Health Plan.

The proposed amendments will do much, we believe, to strengthen the Certificate of Need provisions of the original legislation.

One of the most important factors behind the rise in health care costs is the increasing capitalization of our health care resources. Thus, we look with great favor upon proposals which would establish a uniform review of all Certificate of Need applications, and close loopholes in the review process, loopholes which allow costly duplication of unneeded health care equipment and services.

This year it is estimated that computerized brain and body scanners will cost this nation and its people about a billion dollars, much of that representing unnecessary duplication. Thus, inclusion of major medical equipment in Certificate of Need programs is an absolute necessity.

As drawn, the proposed legislation is unclear whether or not such equipment is covered by the review process, if it is located outside the institutional setting, such as physicians' offices. We believe that Certificate of Need review should apply to equipment in all settings, including doctors' offices, and we urge that the final draft of this legislation clarify this point.

We also question the use of a minimum capital cost, namely $150,000, in determining the definition of major medical equipment. Should not this definition also include consideration of the operational costs of such equipment, whether or not it represents a totally new medical technology, and whether or not its application will be accompanied by the phasing out of some other, obsolete technology?

Health Maintenance Organizations are, in our opinion, an integral part of the health care matrix. We do not believe that they should be dropped from the category of health facilities, and thereby excluded from Certificate of Need and other appropriateness review. It is our earnest wish that alternative health care services of the kind exemplified by HMOs flourish, and we believe the review process can only strengthen them and stimulate their growth.

Extending the review from ninety days to one year while useful for developing comparative analysis or "batching", it may be too permissive without state control.

The amendment to insure that Certificate of Need decisions are consistent with the State Health Plan is another link to attain uniformity and consistency, but is too vague as to who and how this would be done.

The state's role in Certificate of Need is further strengthened by the amendment to all withdrawals of Certificate of Need applications.

The whole question of the use and approval of formula grants has caused great concern among state health officials. We believe that the amendments, as proposed, limit the flexibility of state government to target these important but limited resources and that the authority of the SHCC would be too broad.

Title III of your proposed amendment, the revision of authority for resource development, is a major step for providing the resources and incentives to those areas and facilities most in need of services. Priority given to outpatient services is a definite step in the right direction.

The amendments dealing with Health Systems Agency designations and the improvement in the appeal process, according to state law, and the definitions of consumers, providers, are all very important. The clarification of these relationships will eliminate some of the major points in the carrying out of the Planning Act.

Overall, we believe this bill will result in better integration of regional and state health facility planning and development and Certificate of Need.

In summary, we believe that this legislation, if it incorporates changes we have suggested, will help the states to press forward with health planning, will give them greater control and involvement in the planning process, and will eliminate much of the confusion that has, to this point, attended the field of health planning.

The Association of State and Territorial Health Officials strongly endorses the intentions of this legislation. Our commentary is presented from the perspective of strengthening a useful and desirable proposal.

Mr. ROGERS. Thank you very much, Mr. Webb, for a very concise statement, a very helpful statement. We appreciate your being here.

There is a call to the floor where a vote is taking place, so the committee will stand in recess for 10 minutes. We ask your patience, and we will try to hurry back.

The subcommittee is in recess.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. We apologize for this holdup.

You may proceed.

STATEMENT OF ROGER L. SMITH

Mr. SMITH. Mr. Chairman, Dr. Carter, my name is Roger L. Smith and I am a city councilman from Overland Park, Kans., and chairman of the Mid-America Regional Council in the Kansas-Missouri eight county Kansas City metropolitan area.

I appreciate this opportunity to testify today on the renewal of health planning legislation on behalf of the National Association of Regional Councils.

Accompanying me is Mr. Peter Levy, executive director of the Mid-America Regional Council.

The National Association of Regional Councils was initiated in 1967 by the National League of Cities and the National Association of Counties to assist local government, elected officials, in organizing the rapidly growing number of regional councils.

Regional councils are areawide organizations of general purpose local governments which involve more than one local government and encompass the total regional community. They exist both in densely populated metropolitan areas and sparsely populated rural areas.

Some encompass regions which cross state lines, such as the one in my own area which encompasses part of Kansas and Missouri. Their prime purposes are to increase communication cooperative decision-making, and coordination among local governments. They also review and comment on certain Federal grant applications through the A–95 review.

But, most importantly, they develop policies and programs to meet common problems and guide orderly development of their areas.

More than 600 such regional councils have been established to deal with areawide problems such as growth, energy, transportation, housing, community facilities, manpower, public safety and environmental quality.

Mr. Chairman, NARC supports the substantial planning, management and evaluation principles in the Health Planning and Resources Development Act of 1974. We appeared before this subcommittee last year and urged a 1-year extension on the legislation.

A coherent and rational national health planning and resources allocation process is essential if we are to provide the necessary health care services to all of our citizens.

In our opinion, the act is a positive step in this direction. It provides for the establishment of meaningful guidelines for the develop-

ment and maintenance of the health care system and, most importantly, it provides the opportunity to contain unnecessary cost increases without sacrificing the provision of adequate health care services.

But, after just stating this, I must be candid with the subcommittee: we do not support the institutional arrangements set forth in the statute for administering this planning program, in particular, the mechanisms utilized to translate national health policies and guidelines into programs and projects at the local level.

As you know, the basic unit in this planning system, created in the act, is the areawide Health Systems Agency, HSA. To date, HEW has designated 205 health service areas throughout the country and has, or is in the process of designating, on a conditional basis, HSA's in each area. We understand that currently only 22 of the 205 areas have public regional agencies or general local governments as the designated HSA.

The remainder are free-standing, not-for-profit, corporations, which are substantially outside the control of State and local governments. And, much to our chagrin, none of the 22 so-called public have any meaningful control or involvement in administration of the program.

HEW's legal interpretation of the act has vested virtual plenary authority over health planning in the consumer-provider health planning units established within each of these public agencies and local governments. But more about this situation later.

It is the displacement of State and local governments from exercising the governmental planning and regulatory authorities called for in the act that causes NARC and the other public interest organizations representing state and local governments to call for some basic modification of this current institutional structure established to complement the act.

We are hopeful that, this year, Congress will make these fundamental changes and provide the opportunity for meaningful participation of State and local governments in the administration of the planning and regulatory process required under the Health Planning Act.

As I have indicated, the associations representing State and local governments have a unified position on a series of amendments which we will ask this subcommittee to consider in extending the act.

These changes, in our opinion, will not modify any of the substantial policies and principles established in the legislation that encourage planning and management of an efficient, cost-effective health care system throughout the country.

Our proposed changes concern making the system more responsive to elected, public decisionmakers at both the State and local levels.

NARC will cover only those proposed changes in our joint package that deal with the health systems agency. We understand and other local government associations will present the other changes that impact especially on their areas of interest and concern.

The National Association of Regional Councils urges the subcommittee to give serious consideration to the following 10 modifications:

One: The governing body of a local government or regional planning unit, which is a health systems agency, should be allowed to appoint the agency staff, approve its plans, adopt the annual budget, establish criteria for reviews and review decisions appealed from the separate HSA governing body.

Two: Units—this would be if the local government or planning unit is the HSA. They should have the authority to appoint, as I indicated, agency staff, plans, adopt the budget, establish the criteria.

Mr. CARTER. And not only that, Mr. Chairman. One-third of all of these people would be local officials. I am wondering, in this case, whether we should not just to divide the money and give it to the local agencies. That, in effect, is what we will be doing with this gentleman's proposals.

Mr. ROGERS. All right, thank you. I am sorry to interrupt.

Mr. SMITH. Number two, units of general purpose local government and their regional organizations should be included as parties to which the Secretary of HEW must respond when a request is made for a review of the appropriateness of the boundaries of any health service area.

The Secretary should be enabled to alter the boundaries of health service areas if he concurs with the findings of a state Governor or that a newly proposed health service area is more appropriate, or more completely meets the requirements for health service areas set forth in the laws, in addition to the current circumstance in which he can so alter the boundaries when the current health service area no longer meets the requirements established in the law.

Three: At least one-third of the members of the governing body of any executive committee of a health systems agency shall be public elected officials or their designated representatives from general purpose local government. The only persons to be categorized as representatives of general purpose local government should be those elected officials, or other individuals directly appointed by the local government.

Elected officials shall be considered as a separate category and the requirements concerning allocation of percentage of membership between consumers and providers shall not apply.

Four: Under current law, if the number of members of the governing body of an HSA exceeds 30, the HSA must establish an executive committee to which it delegates the authority to take all actions required of HSA's under the law except establishment and review of the health systems plan and annual implementation plan.

Five: The law should be altered to allow the delegation of any authorities to an executive committee at the discretion of the governing body, rather than requirement of Federal law.

For the sake of clarity, the wording in section—this is a long one—512(b)(3)(C)(3.2) reading "nonmetropolitan" should be changed to read "nonurban." The wording of this subsection should be further altered so that the percentage of representatives of nonurban areas be absolutely equal to the percentage of nonurban areas represented within the HSA's, but instead, is at least equal to that percentage.

Six: It should be specified in the law that, except for confidential meetings called to discuss performance or remuneration of individual

HSA employees, all meetings of the HSA governing body, or executive committee, and any subarea council or committee which it may create, must be open to the public following provision of full notice of that meeting.

Further, all records, excluding only personnel records, must also be open to the public and available upon request.

Seven: Section 512(c) should be altered to encourage health systems agencies to establish subarea councils by substituting the word "should" for the word "may"—and I realize, Mr. Chairman, that you commented prior on the use of semantics. The subarea council should be allowed to carry out any functions of the HSA which the HSA chooses to delegate to it, including planning at the subarea level.

Boundaries for subarea councils should follow existing neighborhoods, local governmental, or regional configurations.

Eight: Each HSA should be required to enter into formal written agreements with the units of general purpose local governments or, in the case of large HSA's, with existing combinations of units of government, which shall include: (*a*) the number of appointments and the process of making appointments to the governing body for health planning; (*b*) the method and schedule for review by the local government or combination of the health systems plan or the annual implementation plan, the agency's application for refunding, and other appropriate policy documents; and (*c*) the process by which suggested changes will be included in review documents and how disputes between the HSA and units of local government will be resolved.

Nine: Upon the denial of a renewal application for a current HSA, or the denial of a redesignation for a health service area, HEW should be required to provide all necessary technical and other nonfinancial assistance, including the preparation of prototype plans of organization and operation to any potential applicant for designation as a replacement HSA.

The law should require that equal consideration should be given to general purpose local governments or combinations thereof in such a circumstance.

Ten: In addition to requiring that the Secretary, in his review and approval or disapproval of the annual budget of each designated health systems agency and State agency, consider the comments of statewide health coordinating councils. The law should also require that he consider comments submitted by units of general purpose local governments and their regional agency within the health service area served by the health systems agency whose budget is under review.

In short, I hope that in crafting a reworked national health planning system over the next year, the Congress will recognize that health, although extremely vital, is not the only concern of State, and especially local governments. The ability to develop compatible plans for health, housing and community development, transportation, aging, and other important concerns is the key to success for mayors and county officials.

I will not recite the list of problems we face daily due to differing Federal agency requirements for such things as the board representa-

tion, citizens participation, accounting procedures, and so on. I will only note that our proposals are all aimed at providing the health planning system with an established point of linkage with the numerous simultaneous ongoing efforts in other fields, all of which have tremendous impact on each other and on the priorities set by local, elected officials for their own budgets.

Just to tie this all up, I guess what we are saying is that if public funds are used in the delivery of health care, we believe a greater role should be played by local elected officials in the normal due process of the general and primary elections within that area.

I appreciate this opportunity.

Mr. ROGERS. Thank you, Councilman, for some very helpful suggestions.

I presume most of the funding will come from the Federal Government, but we do not presume to put Federal officers on those boards.

Mr. SMITH. That is correct.

Mr. ROGERS. Now, I presume, following your theory that if it is local funding, you should have local officials; if it is Federal funding, we should have Federal. But we think it is better to try to get local people involved, even though it is Federal funding. So we have to strike some balance to let the consumer come in, provider come in, and we also want local government involved too.

Mr. SMITH. I guess I look at the source of Federal funding comes from the grassroots. I realize I am on the lowest rung of the political ladder, but I feel I am very close to those people.

Mr. ROGERS. Well, you know even members of Congress are fairly close. In fact, we are elected twice in the time most county commissioners are elected. For instance, they elect county commissioners for 4 years in my area, but I have run two times when he only runs once. I stay pretty close, too. I think we all stay close—at least, I would hope that we would.

Mr. SMITH. Perhaps we should call it taxpayer's money instead of Federal funding.

Mr. ROGERS. I think it is taxpayer's money through the Federal Government and I was using your analogy that if it is local money it ought to be locally used. But it comes from all over the United States and I do not think we ought to have Federal officials there. I think we want local officials to be involved. But we ought to have consumers, the taxpayers themselves involved maybe too, so that we all have an interest.

Because—I even find some of the consumers do not agree with everything I do as an elected official. I do not know whether you have experienced that or not.

But sometimes they like to have a say directly. Would you disagree with that?

Mr. SMITH. No, I agree with you.

Mr. ROGERS. What we want to do—I think you have made your point—but we want to get a balance, a few consumers, some from the local government, providers, so we can all work together.

Mr. SMITH. I guess if you would——

Mr. ROGERS. Rather than let one dominate.

Mr. SMITH. If you would permit a personal reference, that on our local HSA, there are only two elected officials.

Mr. ROGERS. Well, it may be that you should have more than that.

Mr. SMITH. That is the main point that we are driving at.

Mr. ROGERS. I think you made your point.

Mr. Webb, your testimony has been most helpful.

Thank you for being here and for your patience with the committee.

There is another vote. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. Our last witnesses will be Mr. Einar O. Mohn, National Council of Senior Citizens from Menlo Park, Calif.; and Theresa Carmady, representing the National Congress on American Indians.

You are accompanied by——

Mr. PRESS. I am Daniel Press. I am counsel for the National Indian Health Board.

Mr. ROGERS. Thank you.

We welcome all of you, and the committee wants to express to you its appreciation for your patience in staying with us this long. We apologize to you, but the votes are something we cannot avoid.

You may proceed.

STATEMENTS OF EINAR O. MOHN, ON BEHALF OF NATIONAL COUNCIL OF SENIOR CITIZENS, AND THERESA CARMADY, ON BEHALF OF NATIONAL INDIAN HEALTH BOARD, INC., AND NATIONAL CONGRESS OF AMERICAN INDIANS, ACCOMPANIED BY DANIEL PRESS, COUNSEL, NATIONAL CONGRESS OF AMERICAN INDIANS

Mr. MOHN. Well, I would be glad to wait til tomorrow but I come from California and I work for the state, and we have a Governor who fires people.

I am not going to read all of this, Mr. Chairman——

Mr. ROGERS. No, we will put your entire—all of your statements will be made a part of the record in full [see p. 440], so if you would highlight the points that you think we should have, that would be helpful.

Mr. MOHN. I am presently serving as chairman of the advisory council to the California Commission on Health Facilities and I have been involved in health issues, both in my own State in California and nationally for a long, long time.

Today I am testifying on behalf of the National Council of Senior Citizens. It is a nonprofit organization, nonpartisan, made up of over 3,800 clubs across the Nation representing more than 3 million people.

Health care remains a top priority of the council and its members. For years the Congress has discussed and studied this Nation's health care delivery system and, for years, the administration, the

Congress and the people have reckoned with the need for national health insurance.

NCSC has testified repeatedly over the past few years, both before Congress and HEW in support of the Kennedy-Corman National Health Security bill.

Although the health planning act is only 3 years old and HSA's are still in their infancy, we believe a number of problems have arisen which must be discussed. If the HSA's are to perform their mandate of effecting a more efficient delivery system in a meaningful way, they must have the statutory right to access hospital records dealing with cost of financing, patient care costs, and patient discharge data, with full protection, of course, provided for the confidentiality in all patient discharge cases.

From our perspective, another significant problem of the act, as it has been interpreted, is in the composition and selection of the governing bodies of the health systems agencies. The Senior Citizens' National Council are right in the forefront of all of this, because they have, always been one of the moving parties in medicare and the medicaid program.

The National Council recommends that HSA boards be comprised of 60 percent consumers, 25 percent providers, and 15 percent public officials. In this regard, we oppose section 209(b)(1) of H.R. 10460 which would provide elected and nonelected officials representation as consumers on the governing boards.

We have gone through a lot of the different sections which we have pointed out in our presentation that we have given to you. I will not go through those.

Mr. Rogers. All right. We will go over those.

Mr. Mohn. We feel that there must be something done in the matter of outreach to develop the ability to communicate with, and bring into the process, local consumer, labor and public interest groups. A corollary problem associated with the consumer composition of the HSA boards is the difficulty of the consumer representatives fully to perform their function without being constantly overwhelmed by the complex, technical nature of the material.

Unlike the providers, whose bread and butter is the day-to-day function of the health care delivery system the typical consumer does not have the access to professional health staff and professional organizations. This must be corrected.

The HSA board should be comprised of 60 percent consumers, as I said, 25 percent providers, and 15 percent public officials.

The National Council is concerned about the lack of recognition given to the long-term care system in the Health Planning Act. This oversight is surprising, given the fact that fully one-third of the medicaid dollars go to long-term care services. For instance, long-term care services are not found in the list of national health priorities. We strongly believe that due priority ought to be given to develop efficient and adequate long-term care facilities both within and outside the medical model. Therefore, the National Council recommends that long-term care be listed among the priorities set out in section 1502, as well as in section 1620, which deals with the priorities in terms of project grants.

In this regard, we would recommend amending section 1625, project grants, (b)(1) to include moneys for conversion of existing facilities into long-term care facilities including adult day care and day hospitals.

And, Mr. Chairman, the overbedding of hospital beds is a real, real serious problem. It is so nationally, and also in my home State in California. When you start approaching 40 percent overbedding, you are putting a terrific load on the back of the consumer with very little for him to gain.

We applaud the efforts of yourself and the committee for the progressive leadership that you have shown in the field of health. Though we have been critical, today, of the details of the health planning act, we are fully supportive of the concept embodied in the act.

The National Council is an earnest and long-time supporter of health planning and consumer involvement. This act and the proposed revision in H.R. 1040 go a long way in reflecting the philosophy of the National Council and its members.

Again, we recognize the difficulty of resolving as complicated an issue as consumer representation in the health planning process, but we must avoid the danger of having the role of the consumer become one of rhetoric rather than fact.

We have seen the complete failure of the medical profession, the hospital industry and all of the allied disciplines including, of course, their strong supporter, the insurance industry, in contributing anything meaningful in their voluntary system of providing facts and figures, which the HSA's need if they are going to be able to do a meaningful job in their health planning.

And so we strongly recommend that this be something that the committee will give its very serious attention to.

We understand the need for studying this problem, but the time has come, we believe, to act and to implement. We must really begin to come to grips with this very serious problem. We look to you, gentlemen, for that decision.

[Testimony resumes on p. 448.]

[Mr. Mohn's prepared statement follows:]

TESTIMONY BEFORE
THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
January 31, 1978

Statement by
Einar Mohn, Executive Board Member
National Council of Senior Citizens
1511 K Street, N. W.
Washington, D. C. 20005

Chairman Rogers and Members of the Committee, good afternoon. I am Einar Mohn, a Board Member of the National Council of Senior Citizens, and recently retired 1st Vice President and Director of the Western Conference of Teamsters. I am presently serving as Chairman of the Advisory Council to the California Commission on Health Facilities and have been involved in health issues both in my own State of California and nationally for decades.

Today, I am testifying on behalf of the National Council of Senior Citizens. The National Council is a nonprofit, nonpartisan organization, made up of over 3,800 senior citizens' clubs across the nation, representing more than three million members.

The subject of health care is a familiar one to the National Council of Senior Citizens. The Council was born in 1962 to lead the battle for the enactment of Medicare and Medicaid. It was the National Council of Senior Citizens' feeling then and it is our feeling today that making high quality health care available and accessible to all Americans, including the elderly and the poor, is a top priority. The enactment of Medicare and

Medicaid in 1965 and the difficult lessons learned from these programs over the past decade have only reinforced the National Council's reasons for continued existence.

Health care remains the top priority of the Council and its members. For years the Congress has discussed and studied this nation's health care delivery system and for years the Administration, the Congress and the people have reckoned with the need for national health insurance. NCSC has testified repeatedly over the past few years both before Congress and HEW in support of the Kennedy-Corman National Health Security Bill.

We believe the Health Planning and Development Act of 1974 establishes a good foundation on which to structure a new health care delivery system. In fact, we noted at the time Pl 93-641 was being debated, that the local health planning concept, combining consumers and providers in the review, development and allocation of health care resources is an important ingredient of National Health Security. We applauded the push for certificate of need programs, for consumer education and for consumer involvement in the health planning process.

Though the Health Planning Act is only three years old and HSAs are still in their infancy, we believe a number of problems have arisen which must be discussed.

If the HSAs are to perform their mandate of effecting a more efficient delivery system in a meaningful way, they must have the statutory right to access hospital records dealing with cost of financing, patient care costs and patient discharge data, with full protection for the confidentiality of patient discharge data.

From our perspective, another significant problem with the Act as it has been interpreted is in the composition and selection of the governing bodies of the Health Systems Agencies. As one of the founding members of the Consumer Coalition for Health, NCSC stands forthrightly behind their statement that "The Planning Act will achieve its objectives of equitable distribution of health care resources, quality care, and cost containment only if HSAs are controlled by independent consumer majorities accountable to the public they represent." Because the original Act did not provide for a process by which to select HSA Board members many of the boards have been self-initiated and self-perpetuating. The result has been something less than positive. In fact, the Southern Governmental Monitoring Project of the Southern Regional Council in its recent study of HSA Board composition in eleven southern states including 28 HSAs found that they are provider-dominated, that the staff is provider-oriented and their training of board members was seriously deficient. The question of accountability looms large in this context. An educated public, made aware of the existence of HSAs and their purpose and functions, will go a long way in assuring adequate consumer representation, not only on the governing boards but in attendance at meetings of the boards.

Specifically, the National Council would recommend that:

1) The HSA Board be comprised of 60 per cent consumers, 25 per cent providers, and 15 per cent public officials. In this regard, we oppose Section 209 (b)(1) of H.R. 10460

which would provide elected and non-elected public officials representation as consumers on the governing boards.

2) The elderly and handicapped be fairly represented on the HSA governing bodies.

3) A member of the local Area Agency on Aging be on the HSA Board. This is presently accomplished through a Memorandum of Agreement between the Administration on Aging and the Health Resources Administration.

4) Section 209 (b)(2) of H.R. 10460 should be deleted. There is no reason to amend the current language excluding members of the immediate family of a provider from representing consumers on the HSA.

5) Section 209 (b)(2) of H.R. 10460 should be adopted. It provides for more adequate representation of rural consumers on HSAs, and thus conforms to the priorities of the original Act as set out in Section 1502 (1).

6) Section 209 (a)(1) of H.R. 10460 which includes unions as major purchasers of health care should be adopted. It is obvious that unions as well as industry share an interest in the health care system, not only from the perspective of quality and availability of health care but also from the perspective of the cost of health care.

7) Nonprofessional as well as professional health care providers be represented on HSA Boards under the provider category.

8) The Chairman of the HSA governing board and its Executive Committee should be a consumer.

9) Recognition should be given to scheduling of meetings so as not to interfere with the livelihood of the board members.

10) Section 202 (12) should be amended to include at the end of the sentence "but not at the expense of the quality of care."

11) Providers should not vote for the consumer representative either in the case of election to board membership or for membership on the executive committee.

12) Section 216 (e) which provides for public hearings on the proposed Annual Implementation Plan; and which requires public notification at least to 30 days in advance of the time and place of the hearing should be adopted.

13) Like Section 216 (e), Section 212 (b)(A)ii should be amended to include public notification.

14) Section 215 should be amended to include under HSA staff expertise "consumer or organizing experience for the purposes of providing outreach."

Again, NCSC is very concerned over the composition of the HSA Boards and of the boards' accountability to the public. H.R. 10460 unfortunately does not go far enough in resolving this issue. Section 210 in effect says to the HSAs, HEW does not know how you were selected. Tell us and the Secretary of HEW will tell you if the selection process is satisfactory. For example, at the very minimum, there should be adequate recall positions and standard terms of service. Nevertheless, the inclusion within this section of the requirement that there be broad participation in the selection process and that such

participation will be encouraged and facilitated is certainly a step in the right direction.

In this light NCSC would recommend that there ought to be included in the Act, perhaps under the authority of the Statewide Health Coordinating Councils, an adequate outreach and public relations function. By "outreach," we mean the ability to communicate with and bring into the process local consumer, labor and public interest groups.

A corollary problem associated with the consumer composition of the HSA Boards is the ability of the consumer representatives to perform their function without being constantly overwhelmed by the complex technical nature of the material. Unlike the providers whose bread and butter is the day-to-day functioning of the health care delivery system, the typical consumer does not have the access to professional health staff and professional organizations.

Ms. Minnie Gaston, a member of the National Council on Health Planning and Development presented to the Council a resolution, which was adopted unanimously on September 24, 1977, directing the state to look into this problem and make recommendations. We point this out for two reasons: one, because it further substantiates the problem of providing technical assistance to consumers and, secondly, because within the resolution Ms. Gaston remarks that she is aware of the assistance and the roll of the ten Centers of Health Planning. Nevertheless, she concludes, "consideration might be given to the development of an additional Center or <u>network of groups</u> whose primary purpose

would be to provide technical and consultant services to consumer representatives involved in the health planning, decision-making process." (emphasis added)

Finally, Mr. Chairman, NCSC is concerned over the lack of recognition given to the long-term care system in the Health Planning Act. This oversight is surprising given the fact that fully one-third of the Medicaid dollar goes to long-term care services. For instance, long-term care services are not found in the list of national health priorities.

We strongly believe that due priority ought to be given to developing efficient and adequate long-term care facilities both within and outside the medical model. Therefore, NCSC recommends that long-term care be listed among the priorities set out in Section 1502 as well as in Section 1620 which deals with the priorities in terms of project grants.

In this regard, we would recommend amending Section 1625, "Project Grants," (b)(1), to include monies for conversion of existing facilities into long-term care facilities including adult day care and day hospitals.

Mr. Chairman, we applaud the efforts of yourself and the Committee for the progressive leadership you have shown in the field of health. Though we have been critical today of details of the Health Planning Act, we are fully supportive of the concept embodied in the Act. NCSC is an earnest and long-time supporter of health planning and consumer involvement in the health care system. This Act and the proposed revisions in H.R. 10460 go a long way in reflecting the philosophy of the

National Council and its members. Again, we recognize the difficulty of resolving as complicated an issue as consumer representation in the health planning process. But it is important to avoid the danger of having the role of the consumer become one of rhetoric rather than fact.

Mr. ROGERS. Thank you very much, Mr. Mohn, for a very excellent statement. It will be gone over very carefully. Thank you for your presence here today.

Miss Carmady?

Ms. CARMADY. Congressman Rogers, we did submit the written testimony [see p. 450], so I will just briefly summarize our main concerns.

Mr. ROGERS. Surely.

STATEMENT OF THERESA CARMADY

Ms. CARMADY. At this point in the act, there is really not a strong, or clear, definition of the role—or let's say the relationship the HSA's have with the tribes, and this has prevented chaos and it has basically caused a lack of participation by the tribes with the HSA's.

I know that both of you are familiar with the Indian Health Care Improvement Act which was passed just a few years ago, and it did go through this subcommittee.

Mr. ROGERS. Last year.

Ms. CARMADY. Right.

Now, in that act, tribes were called upon to submit tribal-specific health plans in the year 1979 to the Secretary of HEW. Now, the problem we see is that the HSA's are basically ignoring the development of the tribal-specific health plans and at this point it is just really not clear what kind of authority the HSA's really have in identifying reservation-based needs, because the act in no way defines that kind of relationship.

So, as we see it now, the tribes on the one hand are developing these tribal-specific health plans, and then on the other hand, the HSA's are definitely looking into the reservation needs, but at this point no one knows to what extent.

And so we might end up, in 1979, with HSA's submitting one plan and then the tribes, on the other hand, submitting another plan. There is funding within the health care improvement act to develop these tribal-specific health plans and the tribes have been really active in developing those plans, and I think that they will really, you know, prove to be adequate.

But I think, you know, our whole concern is that both the tribes and the HSA's could benefit one and the other and working together, but because that relationship has not been defined, tribes have tended to stay away. And because of, let's say, local problems too—you know, the kind of participation——

Mr. ROGERS. Perhaps your Council could suggest language that we could look at if it might help in this situation and the committee would be glad to review it.

Ms. CARMADY. And on the last page of the testimony there is an attachment from region X. Region X has come out with a very good statement on the relationship between the tribes and the HSA's that basically points out some of the language that might be necessary.

Mr. ROGERS. That would be helpful. If you would be in touch with staff, that will be helpful.

Mr. PRESS. We will be having a National Indian Health meeting in Albuquerque in 2 weeks and we will come back right after that and have an opportunity to meet with your staff.

[Testimony resumes on p. 457.]

[Mr. Carmady's prepared statement and attachments follow:]

STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD, INC. AND THE NATIONAL CONGRESS OF AMERICAN INDIANS BEFORE THE HOUSE COMMERCE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT ON THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 (P.L. 93-641), JANUARY 31, 1978

The National Indian Health Board, formed as a non-profit organization in 1972, advocates that "health care services delivered to American Indians and Alaska Natives should be of the highest quality and of sufficient quantity so that American Indians and Alaska Natives attain an equal or better health condition than other American citizens". NIHB is further organized to "review and comment on all national policies proposed by the Indian Health Service and other federal agencies which serve or should be serving American Indians or Alaska Natives and to recommend to them such policies as are necessary to improve the health services provided by those agencies to American Indians and Alaska Natives". As a result, NIHB has been providing advisory consultative and guidance services for the Indian Health Service and has over the years acquired the knowledge, expertise, ability and desire to perform its vital role to the Indian Health Service and the Indian community.

NIHB provides a mechanism for monitoring national legislation affecting Indian health. In this capacity, NIHB is monitoring the activities of agencies and entities created by Public Law 93-641, the National Health Planning and Resources Development Act of 1974.

Four years after its passage, the impact of P.L. 93-641 upon American Indian and Alaska Native future health services remains unclarified. The Law moves to correct maldistribution of health care through health planning and deals with the rapid increase in health resources locally through the creation of a Health Systems Agency (HSA). Specifically, in relation to Indian tribes and people, HSAs are mandated by P.L. 93-641 to function as providers of certain services. In a statement from the law, these services are:

(1) Each health system agency shall provide each Indian tribe or intertribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of Sec. 1513 (e) (1) (a) of the Act; and

(2) (In reference to proposed use of Federal funds for Indian tribes and Alaska Natives)... a health systems agency shall only review and comment on such proposed use (Sec. 1513 (e) (1) (b).

Each service or function seems harmless, yet both have resulted in numerous unanswered questions and pose serious problems for Indian tribes, Alaska Natives and Indian people generally.

Because the role of the HSA vis-a-vis Indians is potentially an active, though unclarified role, Indian people and tribes raise several issues, one of which is the sovereignty issue. Indian reservations clearly fall within the planning areas of some HSAs. Because of this, the unresolved question is what authority an HSA has over health activities on reservations. Relative to this major question are: Does the "review and comment" authority diminish tribal sovereignty? Do HSA health plans supercede reservation health plans? If, for example, reservation population figures are used in HSA health plans and if funds are appropriated to the states based on that population including Indians, is a share of those funds available to Indian tribes? These questions point out a need to review the whole planning law and its relationship to Indian tribes. Inadvertently or otherwise, P.L. 93-641 does present a very serious threat to tribal sovereignty.

Indian experience with P.L. 93-641 to date shows a patchwork of different relationships established nationally. These relationships range from Indian non-participation to the establishment of sub-area councils for specific tribes. Congress and DHEW have never addressed the relationship between P.L. 93-641 creations and the Indian health care delivery system. Given this failure to address the Indian relationship to the P.L. 93-641 process, each tribe has developed or negotiated a different arrangement depending on (1) the knowledge and bargaining power available to the tribe and (2) the attitude of the non-Indian community towards Indian people. As expected, where a tribe was well informed on the health planning law and had established a firm bargaining position on what it wanted, a favorable arrangement on its participation on the HSA was negotiated. Likewise, if the opposite was true, tribes have had to accept unfavorable roles on the HSA which have compromised tribal sovereignty and other basic tribal rights.

Legislative as well as administrative changes must be effected to make the Health Planning and Resources Development Act more responsive to Indian needs. NIHB believes that many of the problems can be resolved without new legislation if effective guidelines or regulations are issued. At this time, NIHB is not in a position to recommend or point out specific changes or language within P.L. 93-641 However, NIHB recognizes that certain changes must occur in P.L. 93-641. P.L. 93-641 must have an Indian amendment that has specific language requiring HSAs to respect the sovereign status of Indian tribes and requiring DHEW to adopt regulations defining how that should be implemented. In requiring the HSAs to respect the sovereign status of Indian tribes and requiring DHEW to adopt regulations implementing this requirement, flexibility is needed for the different arrangements that tribes have already developed, want, or need with the HSAs.

Secondly, P.L. 93-641 must contain specific language that stresses and utilizes the tribes' own health planning structures and capabilities on the HSA total plan. Also the need for coordination between non-Indian and Indian health systems at points where they meet, i.e., contract care, must be addressed. Thirdly, the HSAs have review and approval authority over the plans and budgets of health providers within their areas. In the Indian case, P.L. 93-641 must provide a mechanism or language that give tribes authority in development of plans for their reservations and to have review and approval authority over the plans and budgets of all direct federal health programs operating on their reservations, as well as over any other non-tribal health programs. Lastly, P.L.

93-641 must address the issue of tribal planning activities by providing a funding mechanism, local or national, for those tribal activities. Again, the NIHB is only pointing these out as areas of P.L. 93-641 in relation to Indians that need clarification or development.

Specific recommendations on P.L. 93-641 addressing the Indian issue will be forthcoming to the Committee from the Second National Indian/Alaska Native Health Conference to be held at the Albuquerque Convention Center, Albuquerque, New Mexico, February 12-15, 1978. This conference, hosted by the National Indian Health Board hopes to produce great strides in the progress of Indian health and to address such crucial issues as raised by P.L. 93-641. After the conference, we would appreciate the opportunity to return to the Committee and discuss with you the specific recommendations on P.L. 93-641 that emerge from the conference.

The NIHB expresses its appreciation to Congress for the opportunity to provide testimony on P.L. 93-641. Furthermore, as part of the written record and attached to this testimony to be submitted, NIHB would like to include Policy Resolution #2 of the Health and Welfare Concerns Committee of the National Congress of American Indians which was passed and adopted by the 34th Convention of the National Congress of American Indians in September, 1977 in Dallas, Texas.

Policy Resolution No.
THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 (P.L. 93-641)
Adopted September 20, 1977

The National Indian Health Board (NIHB) composed of twelve members elected from area health boards designated by the Indian Health Service serves a major corss section of the American Indian population. Since its formation in 1972, NIHB has advocated that "health care services delivered to American Indians and Alaska Natives should be of the highest quality and of sufficient quantity so that American Indians and Alaska Natives attain an equal or better health condition than other American citizens". NIHB is organized to "review and comment on all national policies proposed by the Indian Health Service and other federal agencies which servie or should be serving American Indians or Alaska Natives and to recommend to them such policies as are necessary to improve the health services provided by those agencies to American Indians and Alaska Natives". As a result, NIHB has been providing advisory, consultative and guidance functions for the Indian Health Service. NIHB over the years has acquired the knowledge, expertise, ability and desire to perform its necessary service to the Indian Health Service.

Recently, the National Indian Health Board exercised its responsibility to provide advisory functions for the Indian Health Service and HEW and to insure Indian input at the national level of National Health insurance issues, recommended to HEW Secretary, Joseph A. Califano, that an Indian person be placed on his Health Insurance Task Force. This recommendation resulted in the selection of Cecil Williams, Chairman of the Papago Tribe. His selection assures for American Indians and Alaska Nativ-s that their interests concerning National Health Insurance will be well represented.

NIHB, as a mechanism for the monitoring of national legislation concerning Indian health issues has proven to be successful. NIHB presently is involved in monitoring the activities of agencies and entities created by Public Law 93-641 and what effects those activities have on Indian tribes and people.

Three years after its passage, the impact of P.L. 93-641, the National Health Planning and Resource Development Act of 1974, upon American Indian and Alaska Native future health services remains unclarified. This Act moves to correct maldistribution of health care and to slow the rapid increase in health care cost through the use of Health Systems Agencies (HSA). The authorities vested in these local health planning bodies pose several vexing problems for American Indians and Alaska Natives.

Unresolved questions are:

(1) Does a health plan developed by a HSA supercede reservation health activities?

(2) Could the HSA's "review and comment" authority over certain tribal funding proposals cause them to be not funded?

(3) Are Indian reservations or tribal jurisdictions totally under the authority of HSA's?

(4) Could HSA's close IHS hospitals or eliminate Indian Health Service because they duplicate services of a nearby non-Indian facility?

If and when National Health Insurance is passed, the HSA will probably play a major role in determining how NHI funds are allocated at the local level. In a sense, P.L. 93-641 is the planning component and NHI the financing component of a broad federal health care strategy.

In addition to the HSAs, the Act created various health planning bodies at the state level and a national council on Health Planning and Development. Ten centers of health planning were established around the country to provide technical assistance on health planning and development to HSAs.

IMPLICATIONS OF P.L. 93-641 FOR INDIANS

A. Benefits to Tribes from P.L. 93-641

(1) A mechanism for coordination with the non-Indian health community. As tribal health programs grow, there is a need for improved coordination between them and the non-Indian health community. First, Indian people use the non-Indian health cre systems through contract care and as individuals. Because of this, improved health care services can result from good links between the system. Secondly, by developing good coordination, it will forstall any effort to eliminate the Indian system as duplicative because tribes can demonstrate that efficient and effective sets of linkages between the two systems have already been developed. The HSA system provides a mechanism for providing this kind of coordination.

(2) Planning Expertise.
HSAs, centers for health planning and other parts of P.L. 93-641 systems, are developing a range of skills in the health planning area. As tribal health programs grow, they will need these skills and P.L. 93-641 components can serve as technical resources to tribal health departments and authorities. From the tribe's point of view, it might be useful to receive some technical assistance from a source independent of the IHS system in order to give the tribes a different perspective.

B. Funding

The various P.L. 93-641 components could be a possible source of funding for tribal health programs. The HSAs are authorized to make grants to entities, such as tribes, to do health planning. In a few years, the HSAs will be making developmental grants to entities to establish health services now lacking in their area. P.L. 93-641 also controls funds for the construction and modernization of health facilities. While this part of P.L. 93-641 has not been funded, appropriations may be provided in the near future and tribes could use the funds to build outpatient clinics and other health facilities.

C. Tribal Sovereignty

Indian reservations clearly fall within their (HSA) planning area. The unresolved question is what authority the HSA has over health activities on reservations. The greatest threat to tribal sovereignty posed by P.L. 93-641 was eliminated when Congress took away the authority of HSAs to "review and approve" funding applications submitted to the federal government by Indian tribes and replaced it with language that gives HSAs authority only to "review and comment". However, there are other areas in which an HSA could potentially exercise some authority over reservation health activities.

Presently, there are no clear answers to the question posed on tribal sovereignty and other issues by P.L. 93-641. How they are answered by individual HSAs or by HEW national policy will have major implications for Indian health programs in the future. Therefore, Indian involvement in P.L. 93-641 issues is essential to insure these questions are answered in a way that protects and does not diminish tribal sovereignty and tribal power to set their own health service priorities.

D. Link to National Health Insurance

The health planning legislation is tied to NHI. If tribes do not develop acceptable arrangements with the HSAs now, the negative aspect of the relationship between tribes and HSAs will rpobably be carried over to NHI where the stakes will be much higher. Therefore, P.L. 93-641 must be addressed as part of the Indian community's effort to make NHI responsive to Indian concerns.

P.L. 93-641 has important implications, both positive and negative for Indian health programs. How P.L. 93-641 actually impacts Indian health programs will depend on how effectively the Indian health community pushes its position on HEW and the HSAs in Indian country.

INDIAN EXPERIENCE TO DATE ON P.L. 93-641

It must be stated that Congress and therefore, the federal government has never addressed the relationship between P.L. 93-641 creations and the Indian health care structure. NIHB feels that a focused effort on its part could result in HEW guidelines and legislative amendments that resolve the various issues discussed in the "Implications" section of this statement in the tribes' favor.

Tribal experiences with P.L. 93-641 have been exactly what one might expect, given the failure of Congress and HEW to address the relationship of Indians to the P.L. 93-641 process. As expected, each tribe has worked out a different arrangement depending on (1) the knowledge and bargaining power available to the tribe and (2) the attitude of the non-Indian community towards Indian people. Where a tribe was well informed on P.L. 93-641 and had established its bargaining position on what it wanted, it was able to work out a favorable arrangement on its participation in the HSA. Where those factors were not present, tribes have been forced to accept roles on the HSA that compromise tribal sovereignty and which are generally unfavorable to the tribes.

AGENDA FOR ACTION

A. Tribes clearly need hard information on what their rights are, what their options are, and what kinds of arrangements have been negotiated by other tirbes in the country. Good data on the problems that have arisen is essential back up to any effort to get administrative and legislative action to deal with Indian P.L. 93-641 issues. The most favorable tribal arrangements on P.L. 93-641 resulted when teh tribe had good information on their rights and negotiated hard for a favorable arrangement. NIHB has begun and will continue to collect information on the experiences of tribes around the coutnry who are dealing with P.L.93-641. With its network of area and local health boards, it may prove easier for NIHB to collect information on the problems that tribes have had with P.L. 93-641 and the arrangements they have developed with their local HSAs.

B. NIHB will initiate discussion with the Bureau of Helath Planning and Resource Development on the joint NIHB-HEW development of guidelines on how HSAs must relate to tribes in the areas. Many of the problems can be resolved without new legislation if effective guidelines or regulations are issued.

C. NIHB will seek to provide assistance to tribes that are trying to determine how they should relate to their HSAs or are seeking to alter an unfavorable relationship developed earlier.

To assist in this role NIHB will request the help of the Center for Health Planning, the technical assistance units created by P.L. 93-641. Since one of the cneters is located in Denver, NIHB will ask HEW to have the Denver Center assume nationwide responsibility for Indian matters on P.L. 93-641 and to work with NIHB to provide technical assistance to the tribes. This arrangement would combine the technical expertise of the center with NIHB's knowledge of Indian health concerns to rpovide an effective team for assisting tribes on P.L. 93-641. NIHB nad the Denver Center for Health Planning would then seek to play the broader role of providing technical assistance to tribes on health planning. Due to tribes having to develop health planning skills, assistance from teh NIHB Center team would allow them to benefit from the health planning techniques and innovative ideas developed in the non-Indian health system and would give them a source of assistance independent of IHS.

D. Given the relationship between P.L. 93-641 and NHI, NIHB will direct its Core Group on National Health Insurance to involve itself in the P.L. 93-641 activities to insure that any positions developed on P.L. 93-641 coincide with the Indian position on National Health Insurance.

E. NIHB will develop a set of amendments concerning the Indian position and will attempt to include them in the legislative package that HEW will be sending to Congress. Possible areas for these amendments include:

(1) Language requiring HSAs to recognize the unique status of tribes. This language would also discuss tribal sovereignty.

(2) HSAs have certain authority over health providers in their areas that tribes lack. This is different from the positions of a tribe which develops a health plan for its reservation; it has no authority to make IHS follow that plan. For all the improvements in tribal health capacity, their role vis-a-vis IHS is still advisory. A tribe definitely should have an option or some middle ground between that of being advisory and that of contracting entire programs. One of the recommendations of the American Indian Policy Review Commission is that legislation be adopted requiring IHS to follow any plan developed by the tribe. This kind of provision is contained in the BIA's P.L. 93-638 regulations (272.24). It is appropriate that P.L. 93-641 should have the same provisions since it would give tribes the same authority over their health provider that HSAs are getting over their providers.

(3) A tribal entitlement created to acquire some of the planning funds being provided to the HSAs through an Indian set-aside of percentage of planning funds. The need for these monies, however, should be evaluated closely. Unless theneed is really great, it might be better to seek funding under P.L. 94-437 and P.L. 93-638 since Congress has laready appropriated large amounts of money for these laws.

SUMMARY OF AGENDA FOR ACTION

Due to P.L. 93-641 being an important piece of health legislation, there is a need to provide tribes with information, advocacy, and technical assistance. HEW must be educated to the unique needs of Indian people. Legislative changes must be effected to make the Act (P.L. 93-641) more responsive to Indian needs.

The National Indian Health Board is willing to assume the responsibility for these activities with the willing assistance of NCAI. NIHB has already joined the Consumer Coalition for Health in an effort to improve P.L. 93-641 so that the health care system is more responsive to consumer control.

OPTIONAL FORM NO. 10
JULY 1973 EDITION
GSA FPMR (41 CFR) 101-11.6

UNITED STATES GOVERNMENT

Memorandum



TO : David W. Johnson, M.D., Regional Health Administrator, PHS, Region X
Thru : Chief, HPFB
FROM : Director, DRD
IHS Representative, PHS, Region X

DATE: October 30, 1975

SUBJECT: 93-641 Relative to Indian Reservations/Alaska Native Regions

The following points have been established by the Division of Resource Development as their position relative to Indian Reservation/Alaska Native Regions and PL93-641, and are proposed as Region X policy.

1. Indian Reservations/Alaska Native Regions retain their health planning and development autonomy within the States under PL-93-641. However, they may be designated Sub Areas at their request. Where such a role is developed, a HSA must take into consideration Indian health service development plans in the conduct of their planning and development processes, in addition to review and comment of Indian health grants and proposals as established under PL-93-641.

2. As Health Service Areas circumscribe Indian Reservations/Alaska Native Regions, Health Systems Agencies shall include Indians/Alaska Natives in their membership who are delegated by the governing body of that Indian Reservation/Alaska Native Region. Additionally, HSA's shall encourage such participation.

3. Indian/Alaska Native participation by representation of Indian/Alaska Natives governing bodies shall be encouraged in the formulation of memberships to Statewide Health Coordinating Councils.

4. The provision of technical assistance by Health Systems Agencies and the Regional Center for Health Planning in health planning and development to Indian Reservations/Alaska Native Regions will be encouraged, as will sub-contracting for such assistance as appropriate.

5. Inclusion of technically capable Indian staff to Regional Health Planning Centers will be encouraged.

6. The Regional Health Planning Center Board shall address Indian/Alaska Native concerns as proposed by Indian/Alaska Native governing bodies.

William E. Knestis

Concurrence:

David W. Johnson, M.D.
Regional Health Administrator

Mr. Rogers. Thank you.

Thank you for being here and for bringing this to our attention.

Ms. Carmady. Thank you.

Mr. Press. Thank you for the opportunity to testify. We realize that it is late——

Mr. Rogers. Thank you so much.

The committee stands adjourned until 10 o'clock tomorrow morning.

[Thereupon, at 5:45 p.m., the subcommittee adjourned, to reconvene at 10 a.m. on Wednesday, February 1, 1978.]

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

WEDNESDAY, FEBRUARY 1, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met pursuant to notice at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please. We are continuing our hearings on Health Planning and Resources Development Amendments of 1978. We do have a great number of witnesses today and if the witnesses could, it would be helpful to the committee if each would summarize his or her testimony in about 5 minutes.

Of course, the full statement will be made a part of the record.

We will start with the panel of third-party payors, Neil Hollander, vice president of the Blue Cross Association; Mr. Henry A. DiPrete, representing Health Insurance Association of America, second vice president of the John Hancock Mutual Life Insurance Co.

We welcome you gentlemen to the committee. Your statements will be made a part of the record in full. If you could summarize the highlights for us it would be helpful, you may proceed.

STATEMENTS OF NEIL HOLLANDER, VICE PRESIDENT, BLUE CROSS ASSOCIATION; AND HENRY A. DIPRETE, ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. HOLLANDER. Thank you, Mr. Chairman. I am Neil Hollander, vice president of the Blue Cross Association, the national coordinating entity of the 70-member Blue Cross plans in the United States and Puerto Rico. The comments which follow have been shared with representatives of the Blue Shield Association and they are substantially in agreement with them.

We appreciate this opportunity to share with you our thoughts generally on amendments to the Health Planning and Resources Development Act, and more specifically, on H.R. 10460.

This discussion of amendments to Pub.L. 93–641 comes at a time when the planning structure being amended is still being developed. There have been delays in issuing regulations and in establishing a National Council on Health Planning and Development.

However, significant progress has been made in creating new health care planning organizations at both State and local levels. And much should now be done in isolating the critical elements for success amongst those agencies who have performed well.

We agree with most of the amendments proposed in H.R. 10460 to strengthen health planning at all levels. In addition, we believe it is important that Congress specifically authorize a limit on capital spending to instill sufficient discipline into the planning process.

Because capital structure in many ways dictates the level of use, efficiency and cost of health care services, we feel strongly that capital expenditure limitations are critical to short-term and long-term control of rising health care cost.

Such limits encourage State and local planning agencies to examine the relative value of all needed services from the standpoint of the "affordability" of each. To assure that the limits strengthen existing health planning, we recommend two steps: a transitional moratorium on new capital expenditures followed by a more permanent capital limit program.

Incidentally, those concepts are incorporated in the voluntary cost containment program outlined by the American Medical Association, American Hospital Association and Federation of American Hospitals.

NATIONAL GUIDELINES

A critical problem is the extent to which national planning guidelines should be imposed on local and State bodies. To insure that planning agencies can assess their local needs locally during their developmental period, we recommend either, (1), the deletion of the requirement that Health Systems Plans be consistent with the national guidelines or, (2), an explicit definition that "consistent with" does not mean "the same as."

We also recommend, however, that local agencies justify instances where their goals and standards are not consistent with the national guidelines. This recommendation is based on our belief that emphasis should continue to be placed on assuring a bottom-up development of health plans which reflect, to the extent feasible, the perceived priority needs of providers and consumers at the local level.

Such plans should contain local and State level perceptions of specific health status goals, and specific supply and use requirements associated with attainment of these goals. We recognize the good work already done by this committee and its chairman in resolving this problem.

At the same time, to avoid dissipating national effort on many different goals, Congress could authorize the secretary to rank critical goals and the existing programs that might affect those goals. We would be better served by focusing on priorities and doing them well rather than by trying to do everything at once.

It is equally important that the goals be stated before establishing standards for reaching them. It follows that we support section 201 which would require the secretary to consider State and local health plans as the basis for modifying the national guidelines.

NATIONAL HEALTH PRIORITIES

It is important to emphasize national health priorities in the development of national guidelines and local and State plans. We are especially concerned that provision of primary care services in medically underserved areas receive close attention at all levels of planning.

We further support the proposal to emphasize discontinuance of duplicate and unneeded services and assurance of more appropriate and efficient use of health care services.

CERTIFICATE OF NEED

The creation of effective mechanisms dealing with the acquisition of major medical equipment is critically important to the success of the planning process in insuring the equitable and efficient distribution of health care services. There are four major points I would like to make in this regard.

First, the Blue Cross Association and the Blue Shield Association are deeply concerned with the problem of artificial shifts in the provision of services between hospitals and other providers in order to circumvent regulatory controls.

To address this problem, the Blue Cross Association supports the extension of State certificate-of-need program controls to include capital expenditures for major medical equipment, regardless of setting. The Blue Shield Association has taken a position in support of the use of the reimbursement mechanism to provide strong incentives or sanctions to prevent the proliferation and unwarranted utilization of such equipment.

Second, it is important that certificate-of-need controls be applied to Federal hospitals since they clearly affect the supply and distribution of health care resources.

And third, HMO's should be more subject to no more, and no fewer, controls than other providers. Recognizing the possible problems of HMO's that rely on the traditional delivery system, we recommend that the "special consideration" provision for HMO's be maintained and clearly defined.

Finally, we believe that State certificate-of-need decisions should be subject to appeal by more persons and organizations, such as third party insurers and other relevant entities especially in situations where there are questions of need or affordability.

APPROPRIATIONS REVIEW/RECERTIFICATION

It is not likely that planning agencies will soon have the ability to review all institutional services simultaneously or in a short time period. Therefore, we support the amendment granting the secretary authority to identify the services subject to such review.

In that connection, there is a need for financial incentives to reduce unneeded capacity. To address that problem, we recommend, (1), fixed costs associated with closure or conversion of facilities be recognized by all payers and, (2) a Federal grant program be estab-

lished to defray certain of the fixed costs, such as long-term debt retirement and severance pay for employees. The amendments should establish such a program and projects involving it should be identified as needed in the State health plan.

Finally, Congress should authorize federal funding for demonstration projects to test recertification. We recommend demonstrations in place of the requirement that inappropriate services be eliminated within 4 years because there are many unresolved legal, financial and technical issues associated with the design and administration of such programs.

NEW MEDICAL TECHNOLOGY

Establishment of a national monitoring mechanism to evaluate the introduction of new medical technology to the health system is a key issue which warrants congressional debate. We support the idea of a national, nonprofit commission responsible for policy direction concerning efficacy, use and supply of new medical technology.

HSA FUNDING

We support the proposed amendments involving higher minimum funding levels, variable per-capita funding levels as the served population increases and more aggregate funding to recognize inflation.

However, as aggregate funding levels appear adequate, we recommend against allowing providers, including insurors, to contribute to HSA's and instead recommend allowing HSA's to contract with local persons and entities for services at cost to tap the expertise that many of these institutions have.

HEALTH PLAN DEVELOPMENT

We recommend elimination of the State medical facilities plan and recommend that the State health plan be required to meet the requirements of the former with respect to the ranking of needed services. Similarly, we recommend elimination of the annual implementation plan and integration of its requirements into a health systems plan which ranks need. Such simplification of the plan development process reduces the need for coordination among different plans and places important emphasis on the responsible development of local and State health plans that establish priorities.

INSURER REPRESENTATION

Insurers represent large numbers of consumers and have unique knowledge and skills involving health care financing and delivery. In fact, in many areas Blue Cross plans and Blue Shield plans are the major purchasers of care. We strongly urge that regardless of how insurers are classified, the act continue to require their representation on HSA governing bodies.

Mr. Chairman, you may be interested in Blue Cross's involvement with HSA in health planning. Yesterday I received information on what we have done during the last year. I would appreciate being able to comment on it for a moment.

Eighty-six percent of Blue Cross plans either have health planning conformance clauses in their hospital payment agreements, and/or are located in States where certificate-of-need programs exist.

In addition 81 percent of Blue Cross plans are represented on either local or State health planning agency governing bodies or committees. Eighty one percent of Blue Cross plans are providing data and/or technical assistance to local HSA's on a routine basis.

Finally, you may be interested to know that the Blue Cross Association commissioned the development of Handbook for Consumer Participation in health planning. This handbook has now been distributed to over 14,000 people in this country most of whom are members of boards of HSA's.

Thank you, Mr. Chairman. I will be happy to try to answer any questions or provide any additional specific details that you or your staff may require.

[Testimony resumes on p. 478.]

[Mr. Hollander's prepared statement follows:]

Statement of

THE BLUE CROSS ASSOCIATION

on

H.R. 10460

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

presented to

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

UNITED STATES HOUSE OF REPRESENTATIVES

by

Neil Hollander, Vice President
Blue Cross Association

February 1, 1978

Mr. Chairman, and Members of the Committee. I am Neil Hollander, Vice President of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross Plans in the United States and Puerto Rico. The comments which follow have been shared with representatives of the Blue Shield Association and they are substantially in agreement with them.

We appreciate this opportunity to share with you our thoughts generally on amendments to the Health Planning and Resources Development Act, and more specifically, on H.R. 10460.

The views I shall present reflect the knowledge and experience gained by the Blue Cross organization through the administration of both government and private underwritten health care financing programs and through involvement in health planning at the local, state and national levels. Today, Blue Cross and Blue Shield Plans serve over 90 million subscribers under private programs and an additional 26 million people under government programs.

Overview

Before proceeding to discuss our position on a number of the key Planning Act provisions as they would be affected by the amendments proposed in H.R. 10460, I would like to stress our view that the planning structure created by P.L. 93-641 is still in a developmental stage. Recognizing the complexity of the Act, coupled with the change in Administration, it is not surprising that implementation delays have been encountered, particularly in the issuance of regulations and the establishment of the National Council on Health Planning and Development. In spite of these problems, we believe that significant progress has been made over the past three years in establishing new health planning organizations and processes at the state and local levels.

In the future, as the planning process matures, we must evaluate its effectiveness, both in a broad sense and on a specific health service area basis.

Our present position is generally one of modifying existing provisions of P.L. 93-641 to strengthen the effectiveness of health planning at all levels. In this regard, we agree with the majority of the amendments proposed in H.R. 10460. We also believe, however, that it is important that Congress make one key structural addition to the Act to insure overall planning effectiveness in the future: that is a specific authorization for a limit on capital spending. Without such an addition, it is questionable whether sufficient discipline can be instilled in the health planning process.

Capital Limit Program

In testimony last year on proposed hospital cost containment legislation, the Blue Cross Association supported the general concept of a limit on capital spending that would be administered through the existing health planning structure. We strongly feel that capital expenditure limitations are critical to achieving a near-to-long term effect in the battle to control rising health care costs. Capital structure in many ways dictates the level of use, efficiency, and total costs of health services. In this regard, the efficient use of capital can reduce inappropriate use of health services; for example, the inappropriate use of hospital beds is in part a function of the over supply of beds. The presence of such limits can stimulate critical "affordability" decision-making, i.e., examining the relative value of all needed services and evaluating the cost/benefit trade-offs among needed services by state and local health planning agencies. Such limits can also improve the credibility of the planning process

by giving all participants, providers and consumers alike, the incentive to plan more efficiently and effectively. Finally, such limits can obviate the need for government to interfere unnecessarily in each and every facility's operations.

In developing the precise structure of a capital limit program, primary attention must be given to strengthening, rather than undermining, the existing health planning structure. With this objective in mind, the Blue Cross Associaton recommends that essentially a two-phase program be enacted: the imposition of a transitional moratorium on new capital expenditures, followed by a more permanent capital limit program.

A transitional moratorium would provide three important benefits. First, it would allow planning agencies necessary additional time to establish effective state and local health planning structures. We feel these agencies are in a critical stage of development. The local and state level health plans now being developed will provide important guidance to decision makers under any future capital expenditure limitation program that may be developed. Secondly, a transitional moratorium would signal a dramatic shift in national policy on capital investment in health care services, explicitly recognizing that there is a limited availability of resources for the health care delivery system. Thirdly, a transitional moratorium provides an important incentive for planning participants to develop and implement a long term capital limit program.

It is noteworthy that the health planning and capital-related goals and guidelines issued to date by the National Steering Committee on the Voluntary Cost Containment Program sponsored by the American Medical Association, American Hospital Association and Federation of American Hospital incorporate both moratorium and capital spending limit concepts.

National Guideline For Health Planning

The development and promulgation of national guidelines, i.e., national health planning goals and standards respecting the supply, distribution and organization of health resources, are key components of the national health planning structure. A critical problem which should be addressed by Congress is the extent to which such guidelines should be imposed upon the local and state level planning bodies at this stage of planning structure development.

Since the very purpose of the Planning Act is to stimulate local health planning and decision-making, we strongly recommend that, over the next several years, federal effort should be geared to developing advisory guidelines to provide health planning agencies with initial advice which they should consider in relaton to their unique local environments. This recommendation is based on our belief that emphasis should continue to be placed on assuring a bottom-up development of health plans which reflect, to the extent feasible, the perceived priority needs of providers and consumers at the local level. Such plans should contain local and state level perceptions of specific health status goals, and specific supply and use requirements associated with attainment of these goals.

A major objective of the Planning Act should be to encourage providers, localities and states to plan, not simply to react. It is no secret that budgeting and planning in many health care institutions can be dramatically improved. Our efforts should focus at the local level, to make these processes effective and locally responsible so that the need to appeal to state bureaucracies is the exception rather than the rule.

To insure that planning agencies are allowed this initial period of assessment of local needs without mandatory federal guidelines, we therefore recommend

either that P.L. 93-641 be amended to delete the requirement that the Health Systems Plans (HSP) developed by Health Systems Agencies be consistent with the National Guidelines or that Congress explicitly define that "consistent with" is not to be defined as "the same as." We also recommend, however, that health systems agencies provide written justification in their health systems plans in instances when goals and standards are proposed which are not consistent with the national guidelines.

An additional problem concerns the need for the development of a national health policy which should, to a substantial degree, be based on consideration of the national guidelines. First, if a substantial number of health planning goals are set forth, it is important that HEW provide guidance to other federal agencies, state and local health planning agencies, etc., to insure that, where appropirate, the major goals are implemented. In this vein, Congress may wish to consider authorizing the Secretary to rank critical goals, such that a high level of federal attention is directed at examining the multiplicity of existing federal and non-federal program initiatives which can be expected to affect such critical goals. In this way, the nation may focus on the attainment of a few important goals rather than dissipating its efforts on many goals.

Second, it is important that goals be promulgated before standards are promulgated which affect achievement of those goals. Most recently the opposite approach was taken, thus creating the potential problem of lack of complementarity between goals and standards. For example, pursuit of the "reduction in infant mortality" goal may, in some locations, conflict with the standards respecting neo-natal intensive care units.

In addition to the above recommendations, we support the proposed amendments (Section 201) of H.R. 10460 which would require the Secretary of HEW first, to consider the health plans developed at the state and area-wide level as the basis for modification of the National Guidelines; second, to collect data to determine the extent to which local health systems change to meet the National Guidelines; and, third, to issue reports regarding the relationship of goals and standards to the supply, distribution and organization of health services.

National Health Priorities

It is important that increased emphasis be placed on the consideration of national health priorities in the development of national guidelines and local and state health plans. Such emphasis is especially critical if Congress enacts a national capital limit program which has the effect of stimulating health resource re-allocations. We are especially concerned that the national priority relating to the provision of primary care services in medically underserved areas receive close attention at all levels of planning, since the re-allocation of finite resources is an important Planning Act goal.

Beyond that recommended change, we support the proposed amendment to add two additional national health priorities pertaining to the discontinuance of duplicative and unneeded services; and, to the adoption of local policies to contain health costs and to assure a more appropriate and efficient use of health services. Clearly, these additional priorities would highlight the need to plan health care services within the context of limited resources.

Federal Requirements for the Establishment of State Certificate of Need (CON) Programs and Voluntary Reimbursement Sanctions to Support Effective Local Health Planning

The creation of effective state level regulatory mechanisms dealing with the acquisition of major medical equipment is critically important to the success of the planning process in insuring the equitable and efficient distribution of health care services.

First, both the Blue Cross Association and the Blue Shield Association are deeply concerned with the problem of aritficial shifts in the provision of services between hospitals and other providers in order to circumvent regulatory controls. Specifically, the present national experience with the introduction of major medical equipment, for example, the CT Scanner, suggests that a variety of mechanisms should be employed to prevent abuse of the health planning process.

To address this problem, we support the extension of state CON program controls to include capital expenditures for major medical equipment, regardless of setting. The Blue Shield Association has taken a position in support of the use of the reimbursement mechanism to provide strong incentives or sanctions to prevent the proliferation and unwarranted utilization of such equipment.

Second, it is important that certificate of need controls be applied, in some fashion, to the provision of health services in federal hospitals, since such hospitals clearly affect the health resource supply and distribution requirements of non-federal facilities and services.

Third, the Planning Act should provide that alternative delivery systems, such as HMOs, are subject to no more, and no fewer, CON controls than are imposed on capital expenditures sponsored by providers in the traditional health delivery system. Therefore, we support the proposed amendment (set forth in Section 218) which we understand is directed at assuring such equity.

We also recognize that in some instances potential problems may arise for particular HMOs that rely upon the traditional delivery system to provide certain services to HMO members. For example, an HMO's intent to use existing inpatient facilities on a contract basis may be thwarted for one reason or another by local institutions. Thus, such an HMO may be forced to propose a capital expenditure to provide such services. To address this potential problem, we recommend that the Act's provision for "special consideration" of HMO applications be maintained, with the intent of Congress strictly expressed on this matter.

This provision further helps to insure that HMOs are treated equitably while, at the same time, it provides the public with the opportunity to examine the merits of the individual planning processes of such entities.

Fourth, we feel that the Act should be amended to insure that a wider spectrum of entities and persons are eligible to appeal state CON decisions. Specifically, we would urge that such appellate rights be explicitly made available to third party insurors and other relevant organizations. In this way, an additional "check and balance" is introduced in the review and approval process, especially in cases where it is possible that an HSA and state agency have approved a project which is questionable in terms of need or affordability, or where the positions of the two agencies conflict.

Appropriateness Review of Institutional Health Services/Recertification

The identification of excess capacity through the HSA and state agency appropriateness review function raises a set of problems that should be addressed by Congress. The Act now specifies that all institutional health services must be reviewed periodically to determine their appropriateness. It is not clear

that health planning agencies will have, in the foreseeable future, the necessary resources, the technical competence, or the real need to review all institutional health services simultaneously or over a short time period. Accordingly, we support the proposed amendment which grants the Secretary the authority to identify the specific institutional health services subject to appropriateness review. We recommend, however, that high priority be given to those institutional health services which bear the potential for significant and costly duplication.

Also, it is clear that one obstacle to the elimination of excess capacity relates to the financial consequences of such elimination to the provider. The creation of financial incentives for providers to reduce unneeded operating capacity can play a key role in efforts at the local level to redistribute capital toward a more efficient delivery system. Congress should provide financial incentives which may, in the short term, stimulate voluntary provider initiatives and, in the longer term, complement any needed regulatory initiatives.

To address this problem we recommend first, that the fixed costs associated with the closure or conversion of portions of a facility be recognized by all payers.

Second, a federal grant program should be created to defray certain fixed costs associated with total facility closures or conversions such as long-term debt retirement and severance pay for employees. It is important that Congress create such a program to signal public acceptance of responsibility for existing excess capacity much of which was constructed with public funds. Of course, such a program would not minimize the need for health insurors and other responsible community organizations to play an important role in hospital closures.

Accordingly, we recommend first, that the proposed amendments to Title XVI be expanded to establish such a program; and, second, that projects eligible for grants, loans and loan guarantees under Title XVI be required to be identified as needed in the State Health Plan (SHP).

Finally, Congress should authorize federal funding to test recertification program concepts through a limited number of state demonstration projects. Emphasis should be placed on evaluating the unresolved legal, financial and technical issues associated with the design and administration of such programs. We, therefore, view as premature, and recommend against adoption of, the proposed amendment set forth in Section 219 which provides that, within 4 years, states must adopt programs which require that institutional health services deemed inappropriate may not be offered. Such an amendment may be appropriate after the results of demonstration programs are analyzed.

New Medical Technology

Establishment of a national monitoring mechanism to evaluate the introduction of new medical technology to the health system is a key issue which warrants Congressional debate. Generally, we support the concept of a national, not-for-profit commission or organization which would be responsible for providing the public with policy direction concerning the efficacy, and appropriate use and placement, of new medical technologies as they emerge.

To help assure the appropriate use and placement of new medical technologies at the local level, reliance should be placed primarily on third party payer reimbursement incentives or sanctions and state level certificate of need processes.

Health Systems Agency (HSA) Funding

In the aggregate, current HSA funding levels appear to be adequate to accomplish the functions required of such agencies under P.L. 93-641; we understand, however, that problems are being encountered by small agencies funded at the minimum level of $175,000. Congressional attention should be directed at assuring that the minimum grant level is adequate to cover the fixed costs associated with the establishment of smaller HSAs. It is also recommended that DHEW evaluate the allocation of Federal Funds to HSAs solely on the basis of population. It is possible, for example, that geographical factors and economies of scale achieved in larger agencies may need to be taken into account in the determination of appropriate funding levels.

Accordingly, we support the proposed amendments in H.R. 10460 pertaining to increased minimum funding levels, the establishment of variable per capita funding levels as the population size served by the HSAs increases, and increased aggregate funding to recognize inflation.

The general adequacy of federal funding levels, however, suggests that private provider contributions, including insuror contributions, are unnecessary. We have seen no empirical evidence to the contrary. Accordingly, we recommend that the Act not be amended to allow private provider financial contributions to HSAs. Rather, we recommend that the Act clearly specify that HSAs are allowed to provide services at cost to local persons and entities on a contract basis, with the stipulation that HSAs not be allowed to enter into such contracts with direct providers of care. Such contract allowances have the primary benefit of enabling the HSA to respond to local health planning issues on a timely basis even when exploration of such issues cannot be accommodated within the limits of the agency's federal funding.

Health Plan Development

P.L. 93-641 requires the development of Health Systems Plans (HSP) and Annual Implementation Plans (AIP) at the local level and State Health Plans (SHP) at the state level. In order to be eligible for federal grants, loans and loan guarantees under Title XVI of the Act, each state must also adopt a State Medical Facilities Plan (SMFP). Further, the Act requires that the AIP establish objectives to achieve the goals set forth in the HSP and establish priorities among the objectives. The Act also requires that the SMFP establish priorities among the projects in a state eligible for Title XVI funding.

We recommend adoption of the proposed amendment (Section 302) which simplifies the plan development process by eliminating the State Medical Facilities Plan. In addition, we recommend that the State Health Plan be required to meet SMFP requirements -- particularly with respect to the ranking of needed services. Also, the Health Systems Plan development provision should be amended to assure that goals are both ranked and expressed in terms of their capital and operating cost implications. Thus, the results of the planning process would be expressed through two key plans, the HSP and SHP -- each of which would rank goals and objectives. Since these Plans generally have a 5 year planning horizon, each should contain a one year component similar in structure and content to the now-required AIP.

Such simplification of the plan development process reduces the need for coordination among different plans and places important emphasis on the responsible development of local and state health plans that establish priorities.

Insuror Representation on HSA Governing Bodies

We understand that amendments may be proposed that would re-classify insurors as consumers instead of as indirect providers. Such re-classification, in the absence of additional amendment, would remove the existing requirement that HSA governing bodies contain at least one insuror representative.

Insurors represent large numbers of consumers and offer unique and necessary expertise and perspectives concerning the interrelationships of the health financing and delivery systems. In fact, in many areas, Blue Cross Plans and Blue Shield Plans are the major care purchasers. Accordingly, we strongly urge that, regardless of how insurors are classified, the Act continue to require their representation on HSA governing bodies.

Mr. Chairman, we appreciate the opportunity to appear before you to present our views. We will be pleased to answer any questions or provide whatever assistance the Committee may require in its deliberations on this important legislation.

Mr. ROGERS. Thank you very much for your testimony. The committee will be in touch with you.

Mr. DiPrete.

STATEMENT OF HENRY A. DiPRETE

Mr. DIPRETE. Thank you, Mr. Chairman. My name is Henry DiPrete. I am second vice president, group operations of the John Hancock Mutual Life Insurance Co. I appear on behalf of the Health Insurance Association of America.

I am here today to comment on H.R. 10460, the Health Planning and Resources Development Amendments of 1978, and to offer our suggestions for how the act can best be strengthened. But first, Mr. Chairman, please allow me to provide some brief background information.

The Health Insurance Association of America has over 300 member companies who write over 80 percent of all health insurance underwritten by insurance companies in the United States.

Our member companies have actively participated in the community health planning effort for more than 11 years. Our involvement actually began before passage of Pub.L. 89–749.

As soon as this Comprehensive Health Planning Act of 1966 became law, the Health Insurance Association moved aggressively to put into action our commitment to consumer and community participation in health planning. Top executives of our companies went to several State Governors to express this commitment and offer our help in initiating the planning effort.

Today there are more than 250 representatives of our member companies serving on State health coordinating councils, health systems agency boards, committees and subarea councils, and our association has a central staff for technical assistance.

In the beginning, we provided seed money which helped local agencies organize and qualify for Federal funding. Subsequently, our companies provided backup for local planning agencies with personnel and money on a continuing basis. From 1973 through 1975, insurance companies contributed approximately $1.5 million to area-wide agencies.

Insurance companies take health planning seriously. We are committed to broad citizen participation in the development of effective and accountable health care delivery systems for everyone. However, we are not satisfied that the concept of community health planning has reached its full potential.

The problems we face are numerous and complex. Gross inequities and inappropriate economic incentives plague our health care delivery and financing system. Inflationary hospital and medical costs are spiralling out of control, and seem to rise with little or no relation to productivity, accessibility, appropriateness, or even quality.

Indeed, the Health Planning and Resources Development Act of 1974 was a big step. Although health planning has suffered growing pains, it is nonetheless beginning to grow, despite ambitious goals and objectives, confusing Federal guidance, and inadequate efforts by HEW to communicate with the public.

With your permission, Mr. Chairman, I would like to file our written statement for the record [see p. 481], but review what we feel are four pertinent points for consideration by this committee.

First, the current HSA structure does not lend itself to efficient and knowledgeable decisionmaking because it does not facilitate the involvement of all groups, consumers and providers affected by health care issues. A consumer majority should be maintained, however, we believe third-party payers, hospitals and physicians should be guaranteed a place on the HSA board and consideration should be given to adding criteria for eligibility to board membership which takes into consideration general knowledge about health care, community needs, and community involvement.

We also believe our expertise and experience would be a valuable asset to both the State Health Coordinating Council (SHCC) and the National Council. A guaranteed position on those bodies will insure our ability to participate.

Second, certificate-of-need programs have been somewhat effective in dealing with capital considerations. In many instances, the presence of a certificate-of-need program has stopped some providers from submitting applications for unneeded capital projects and has resulted in modifications in many projects which would not have been altered if the program was not in existence.

However, there are still problems with the certificate-of-need program whose solution would add to its strength. For example, recently a problem has developed in Massachusetts. We see the likelihood of its developing in the United States in 1978 and 1979.

Several bills have passed the State legislature which, by specific intent and design, circumvent the State's certificate-of-need allowing capital expansion after the State-certifying agency has denied the application and the decision was affirmed on appeal.

A possible solution would be to establish medicaid and medicare reimbursement sanctions for new health care projects not found to be needed by the State Health Planning and Development Agency under a certificate of need program meeting the requirements of Public Law 93–641.

Capital and operating costs associated with a project not found to be needed would be excluded from Federal reimbursement under medicaid and medicare unless the secretary, after consulting with State and local planning agencies, decided otherwise.

I would like to file for the record a proposed draft of the legislative change to effect that.

Mr. Rogers. That would be helpful [see p. 492].

Mr. DiPrete. Third, coordination between the HSA's and PSRO's is important. Currently, that coordination is insufficient. To develop the HSP, the HSA must have a reasonable data base which it is unable to acquire without the assistance of the PSRO.

This committee recognized the need for the linking of HSA's and PSRO's during your consideration of hospital cost containment. That proposal required State cost containment programs who wanted Federal dollars to line the three interrelated programs, for example, HSA's PSRO's, and the State ratesetting commission.

However, it must be pointed out that PSRO's strenuously resist this linking and sharing of data because of the fear that the privacy of individual medical records will not be preserved as these records are aggregated and released to the HSA's for planning purposes.

The implementation of community health planning will continue to be weak as long as there is not adequate provision for the collection of accurate data for the HSA's and State Health Planning and Development Agencies. In order to insure the collection of adequate data, we believe a special advisory committee of the national center for health statistics should be created which will review and approve the activities of the national center and guarantee input from the private sector.

Fourth, the basic functions of the State agency appear to be workable. We feel it is important to insure that the State agency properly consider the local plan in the development of the State plan. We do not think the State plan should be submitted to the Governor for prior approval, however, he should have the opportunity to review and comment on the State plan.

Mr. Chairman, we tried through our testimony to be as candid and constructive as possible on this important issue expressing our feelings as well as ideas. We hope our comments will assist the committee in its deliberations.

[Testimony resumes on p. 493.]

[Mr. DiPrete's prepared statement and attachment follows:]

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

ON

HEALTH PLANNING AND RESOURCES DEVELOPMENT LEGISLATION

Presented by

HENRY A. DIPRETE

Before The
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT
of the
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

February 1, 1978

My name is Henry A. DiPrete. I am Second Vice President of the John Hancock Mutual Life Insurance Company. I appear today on behalf of the Health Insurance Association of America.

The Health Insurance Association of America has over 300 member companies who write in excess of 80 per cent of all health insurance underwritten by insurance companies in the United States.

We and our member companies have actively participated in the community health planning effort for more than eleven years. Our involvement actually began before the passage of P. L. 89-749.

As soon as the Comprehensive Health Planning Act of 1966 became law, the Health Insurance Association moved aggressively to put into action our commitment to consumer and community participation in health planning. Top executives of our companies went to several State Governors to express this commitment, and offer our help in initiating the planning effort.

In the beginning we provided seed money which helped local agencies organize and qualify for federal funding. Subsequently, we provided back-up for local planning agencies with personnel and money, which from 1973 to 1975, amounted to approximately 1.5 million dollars. Today, there are more than 250 representatives of our member companies serving on SHCCs, HSA boards, committees and subarea councils, and our Association has a central staff for technical assistance.

Insurance companies take health planning seriously. We are committed to citizen participation in the development of effective and accountable health care delivery systems for everyone. However, we are

not satisfied that the concept of community health planning has reached its potential.

Health planning has suffered growing pains, however, it is beginning to grow despite ambiguous goals and objectives, confusing federal guidance, and inadequate efforts to communicate with the public by DHEW.

Comprehensive health planning, at the areawide and state level, has been turned into a plodding, academic exercise. Elaborate inventories of resources are attempted, yesterday's needs are estimated and fed into computers to suggest planning sophistication which often results in diverting energies from the serious issues we face.

These issues are here and now. How we deal with them will set a pattern for many years in the future. We must plan for the following major issues:

1. The inequities in the amount and quality of health care delivered that are produced by uncoordinated methods of delivery, financing and policy development;
2. Inflationary hospital and medical costs that persistently rise with little relationship to productivity and accessibility and with questionable relationship to appropriateness and quality;
3. The lack of ambulatory services which meet individual and community needs;
4. The lack of effective and responsive means for meeting the health care needs of the central cities and rural areas; and

5. How to utilize the undeniable potential of combining the resources of the public sector and the private sector, the professional and the layman, to try to get them to function effectively, responsively, and accountably together for the health of all Americans.

With your permission, Mr. Chairman, I'd like to take just a few minutes to review some of the principal provisions of H. R. 10460 from the perspective of the major issues I've mentioned.

The priorities mentioned in the bill are important and call for active attention. However, they should be expanded to include the training and increased utilization of physicians' assistants, the increased utilization of health management, administrative, and planning personnel, and other types of needed allied health professionals. The development and updating of priorities could well be a continuing responsibility of the National Council of Health Planning and Development.

The keystone to an effective and accountable health planning effort is across-the-board involvement at the community level of all involved parties. We have supported this idea consistently; it is in keeping with a basic American tradition.

Insurance companies have consistently supported the concept of a major role by consumers in health planning at all levels. In many cases consumers have been intimidated by provider "experts". Consumer participants, who have not had adequate opportunity to prepare, feel no one is listening to

what they say. A result has been spotty participation by consumers; although, with adequate time, improved communication, clearer goals, and particularly a renewed spirit of partnership, consumer input can be a dynamic force.

The current HSA structure does not lend itself to efficient and knowledgeable decision-making; because it does not facilitate the involvement of all groups, consumers and providers, affected by health care issues. A consumer majority should be maintained, however, we believe third-party payors, hospitals, and physicians should be guaranteed a place on the HSA board; and, consideration should be given to adding criteria for eligibility to board membership which takes into consideration general knowledge about health care, community needs, and community involvement. We also believe our expertise and experience would be a valuable asset to both the SHCC and the National Council. A guaranteed position on those bodies will insure our ability to participate.

Under current law HSAs have been assigned responsibilities that may be unreasonable in view of the current structure of the agencies and the resources available. We suggest a method be developed to phase-in the tasks and responsibilities assigned to HSAs in accordance with their ability to perform and allow SHPDAs and SHCCs to perform those tasks not delegated to an HSA.

Certificate-of-need programs have been somewhat effective in dealing with capital considerations. In many instances the presence of a certificate-of-need program has stopped some providers from submitting applications for "unneeded" capital projects and has resulted in modifications

in many projects which would not have been altered if the program was not in existence. However, there are still problems with the certificate-of-need program whose solution would add to its strength. For example, recently a problem has developed in Massachusetts. Several bills have passed the state legislature which, by specific intent and design, circumvent the state's certificate-of-need program. These special acts exempt named institutions from certificate-of-need allowing capital expansion after the state certifying agency has denied the application and the decision was affirmed on appeal. Although we do not have a solution for this problem, we do want to raise the issue and begin its examination.

Another problem we want to raise is the lack of a time constraint on the issuance of a certificate-of-need. We believe a reasonable time frame should be placed on the duration of a certificate-of-need during which construction must be begun or a valid contract signed for delivery of a major piece of equipment.

There is also room for improvement in current federal certificate-of-need guidelines. Major technology whose purchase, lease or installation requires substantial capital investment and/or a substantial increase in annual staffing and operating expenses should, regardless of its setting, be included in the certificate-of-need regulations. Other areas which should be included in the federal guidelines for certificate-of-need are:

a) modernization, which includes alteration, repair, remodeling, replacement and renovation of existing buildings including initial equipment and replacement

of equipment in existing buildings;

b) federal facilities should come under the review and comment process with state recommendations filed with Congressional appropriation committees;

c) expansion of the definition of health care facility to include free standing organized ambulatory care facilities, referral laboratories, diagnostic x-ray facilities, etc.;

d) leasing or acquisition of sites; and

e) home health care programs.

We also believe that a certificate-of-need process tied to an effective prospective rate/budget review system will be the most effective means of controlling institutional health care costs.

Coordination between the HSAs and PSROs is important. Currently, that coordination is insufficient. To develop the HSP, the HSA must have a reasonable data base which it is unable to acquire without the assistance of the PSRO.

This committee recognized the need for the linking of HSAs and PSROs during your consideration of Hospital Cost Containment. That proposal required state cost containment programs who wanted federal dollars to link the three interrelated programs, i.e., HSAs, PSROs and the state rate setting commission. However, it must be pointed out that PSROs strenuously resist this linking/sharing of data because of the fear that the privacy of individual medical records will not be preserved as these records are aggregated and released to the HSAs for planning purposes.

The implementation of community health planning will continue to be weak as long as there is not adequate provision for the collection of accurate data for the HSAs and SHPDAs. In order to insure the collection of adequate data, we believe a special Advisory Committee to the National Center for Health Statistics should be created which will review and approve the activities of the National Center and guarantee input from the private sector.

There must be realistic financing for local planning agencies. We believe the authorization levels in H. R. 10460 will be sufficient. However, we believe the authorization levels should be extended for a three year period.

The entire matter of the state role in health planning requires further consideration. We lean toward a state health planning authority to which the local planning agencies can relate directly. The line of responsibility and authority should be to the state. However, except for states with fewer than 700,000 inhabitants, the state should not take over the whole planning process and, in any event, must allow for reasonable variation by local area of both goals and methods of reaching those goals.

It has been our experience that the planning process benefits from an active and responsible advisory body. We believe, however, that present arrangements and practices need strengthening; e.g., the governing board composition we proposed for local agencies should also apply here.

The basic functions of the state agency appear to be workable. We feel it is important to insure that the state agency properly consider the local plan in the development of the state plan. We do not think the state plan

should be submitted to the Governor for prior approval, however, he should have the opportunity to review and comment on the state plan.

In our opinion, decertification authority must be given to state certificate-of-need agencies in order to have an effective health care cost control program. Currently, there is no way to eliminate unneeded and duplicative health services unless the provider does so on a voluntary basis. The state certifying agency after appropriate review and comment from the local HSA should have the authority to decertify existing facilities and services found to no longer be needed. The appropriateness review process when developed by HEW will be an invaluable tool to the local and state agencies in this regard.

We recognize that H. R. 10460 does not contain decertification authority. It is our belief that the language on decertification contained in H. R. 6575, The Hospital Cost Containment Act of 1977, which has been reported by this subcommittee is sufficient to solve this problem, and we recommend it be included in these amendments.

Many of the regulations promulgated by DHEW have created problems and confusion for HSAs. It is true that some areas where regulations have not been issued by DHEW are in new, complex areas and, therefore, take time to be developed. However, the certificate-of-need guidelines were only issued in January, 1977. They contain many loopholes which have not been corrected by the Secretary. The certificate-of-need program at the state and local level has, therefore, been unable to proceed as quickly as was envisioned.

National Guidelines for Health Planning required under Section 1502

of P. L. 93-641 have as yet not been issued in final form. It is estimated that final guidelines will not be published until some time in 1978.

The draft guidelines for the State Medical Facilities Plan were issued in August, 1977 and did not address long-term care and ambulatory care facilities. In addition, the State Medical Facilities Plan calls for coordination with the appropriateness review process. Neither appropriateness review guidelines nor regulations have as yet been published by the Department of Health, Education and Welfare.

Section 1533 (d) of P. L. 93-641 required the Secretary to establish within one year a uniform system of cost reporting, cost accounting, and a uniform system for calculating rates. We recognize that this committee has led the fight to see these systems implemented and we hope it will continue to strive to accomplish that goal.

We believe the ten regional health planning centers can provide a useful service. However, to date, their performance has been uneven. We believe a needed service they could provide, although they were not established for this purpose, is support in the education of board members.

No reasonable person could suggest that our health delivery system can effectively handle the needs of our citizens without an effective planning process. However, whether P. L. 93-641 is the best way to have effective health planning is a question that is too early to answer. The implementation of the Act is still in the formative stage. Regulations are still being developed by DHEW and the force of the Act's regulatory scheme has not been fully felt. However, in many areas the HSAs' influence is being recognized by state

certificate-of-need agencies. The Act is still young and ought to be given the opportunity to succeed.

Mr. Chairman, we tried through our testimony to be as candid and constructive as possible on this important issue expressing our feelings as well as ideas. We hope our comments will assist the committee in its deliberations.

PROPOSED SOLUTION TO STATE LEGISLATIVE
CIRCUMVENTION OF CERTIFICATE-OF-NEED

If a new institutional health service, as defined in Title XV of the Public Health Service Act, is not found to be needed by the state health planning and development agency designated pursuant to section 1521 of such Act under a certificate-of-need program found satisfactory to the Secretary as required by section 1523 of such Act and in accordance with procedures and criteria prescribed by section 1532 of such Act, the Secretary, in determining Federal payments to be made under Titles V, XVIII and XIX (of the Social Security Act) for services, shall not include--

(1) an amount equal to ten times any amount attributable to depreciation, interest on borrowed funds, a return on equity capital (in case of proprietary facilities), or any other expense related to a capital expenditure made for the provision of such new institutional health service, or

(2) any amount for direct operating costs or charges for the provision of such service,

unless he determines; after taking into account any recommendations made by the State health planning and development agency and the health systems agency designated under section 1515 of the Public Health Service Act for the health service area in which the new institutional health service is to be offered, that such service is necessary for the effective and economical delivery of health services under Titles V, XVIII or XIX.

Mr. ROGERS. Thank you very much, Mr. DiPrete, for a very helpful statement and the suggestions. If you will let us have language that will be helpful.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Who would be responsible for approving certificate-of-need applications?

Mr. HOLLANDER. Is that certificate-of-need agency, sir?

Mr. CARTER. Yes, certificate-of-need agencies. What are these?

Mr. HOLLANDER. HSA's or SHPDA's, that is in States where certificates-of-need come into play, there are qualifying Federal and State laws on particular agencies responsibility for reviewing and making decisions. The HSA's advise the principals.

Mr. CARTER. I beg your pardon.

Mr. HOLLANDER. The HSA's are responsible for making recommendations to such agencies and advising them. They are responsible for that, if I understand you correctly.

Mr. CARTER. HSA's actually do the groundwork and the SHPDA makes the final decision. Would you have the Governor make the final assessment on the certificate of need?

Mr. HOLLANDER. No, sir. I think it is the responsibility of the agency.

Mr. CARTER. Would you have 25 percent of HSA's composed of elected officials and counted as part of the providers?

Mr. HOLLANDER. It would be our recommendation that that not become a mandated part of the law. We believe that the purpose and intent of the Planning Act was to develop a local planning process between providers and consumers. To mandate the requirement that local officials make up 25 percent of the boards would not be in the spirit of the act.

Mr. CARTER. Mr. DiPrete, I would like to ask you about what percentage of the membership of HSA boards are insurers who are providers, or who are considered as providers.

Mr. DIPRETE. We have 250 representatives from the insurance companies serving actually on HSA's or State health care coordinating committees. The majority are serving on HSA's.

Mr. CARTER. I notice you would like to see the consumer group increase. Is that correct?

Mr. DIPRETE. Yes sir.

Mr. CARTER. You would be willing to have insurers classified as providers. Is that correct?

Mr. DIPRETE. The present law calls for 60 percent, up to 60 percent to be consumers, I believe. We feel that as long as the majority or in that neighborhood are 60 percent we are supportative of giving the law a better chance to work as it is now constituted without changing it.

Mr. CARTER. You say you want to increase the number of consumers. I have no argument with that. In case you do that, of course, everyone must give and as a representative of the health insurance group with 250 members on HSA's, are you willing to furnish a number in order to accomplish this purpose?

Mr. DIPRETE. If it became consumer versus providers, we would yield to the consumers.

Mr. CARTER. You would have to yield. I am trying to have you put it in concrete if you would like it that way. At least 51 percent of the consumers but not more that 60 percent is the present requirement, of course.

I notice that you want certificate-of-need controls on Federal hospitals, too. Is that correct?

Mr. HOLLANDER. Are you talking to me, Dr. Carter?

Mr. CARTER. That is part of your statement.

Mr. HOLLANDER. That is true. It is the Blue Cross Associations view that we have to be concerned about all health care facilities in this country. In many localities Federal hospitals are a major part of the health delivery system and we feel they should be subject to such planning as voluntary hospitals are.

Mr. CARTER. Veterans in many instances are not receiving the best treatment which we think those who served our country really deserve.

Mr. HOLLANDER. I think all people in this country should receive the best treatment that is possible irrespective of the source of that treatment. With certificate-of-need, there is responsibility to insure that quality of care will be appropriate along with quantity.

Mr. CARTER. You do not think that veterans should get any preferential treatment or should have better hospitals. Is that correct?

Mr. HOLLANDER. I did not say that.

Mr. CARTER. In effect?

Mr. HOLLANDER. No; I believe Veteran's Hospitals should be subject to the same requirements of review as other hospitals. I do believe that people who served this country should receive the full support of the people in Congress. I think the issue of certificate-of-need associated with such hospitals is a sensitive question.

Mr. CARTER. What about certificate-of-needs for HMO's?

Mr. HOLLANDER. You notice in our testimony we said that we strongly believe that HMO's should be supported equally. Blue Cross has, itself, fostered many HMO's and has supported the development of all kinds of alternative delivery systems. We do not feel, however, that a special exemption from the public process of review should be granted to anyone.

The present Health Planning Act does provide for making special exemptions in some instances, but it requires that the planning review process take place. In some parts of the country, the size of HMO's has already reached a point where it is hard to argue that they are a small fledgling developing institution.

Mr. CARTER. We are now requiring them to furnish the services which they were supposed to furnish according to the original legislation.

Mr. HOLLANDER. I am sorry, I did not hear the first part of the question.

Mr. CARTER. It was not a question. It was a statement.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Hollander, I believe you recommended that fixed costs associated with closure or conversion of facilities be recognized by all payers?

Mr. HOLLANDER. Yes, sir.

Mr. ROGERS. How would you propose it be done and change the law necessary?

Mr. HOLLANDER. I do not believe that a change in the law is necessary. I would like with permission to review the medicare and medicaid laws and make suggestions.

Mr. ROGERS. That would be helpful to the committee.

Thank you both for being here. Your testimony has been very helpful.

Mr. HOLLANDER. Thank you, Mr. Chairman.

Mr. ROGERS. The next witness is Mr. Gemmell, associate director, National Association of Counties. Welcome to the committee. Your statement will be made a part of the record in full. If you will highlight it for us, the committee will appreciate it.

STATEMENT OF MIKE K. GEMMELL, ASSOCIATE DIRECTOR FOR HEALTH AND EDUCATION, NATIONAL ASSOCIATION OF COUNTIES (NACo)

Mr. GEMMELL. Thank you Mr. Chairman. Mr. Chairman and members of the subcommittee, my name is Mike Gemmell, associate director for Health and Education of the National Association of Counties, (NACo), and I am here today to present our views on H.R. 10460.

NACo is the only national organization representing county government in America. Its membership includes urban, suburban, and rural counties joined together for the common purpose of strengthening county government to meet the needs of all Americans.

By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals. That is improving county government, serving as the national spokesman for county government, acting as a liaison between the Nation's counties and other levels of government and achieving public understanding of the role of counties in the Federal system.

In the interest of time, we are submitting for the record a detailed statement of our proposed amendments to the National Health Planning and Resources Development Act [see p. 499]. I shall confine my remarks to our major concerns.

The National Association of Counties is strongly in support of a truly local health planning system. These agencies, we believe, should play a key role in the containment of costs and the implementation of a national health financing system. They must also provide the stimulus for providing services in underserved areas and encourage the kind of public health and prevention activities which offer the greatest potential for long-term improvement in health status.

However, planning in general and health planning in particular are intensely political activities. It is the process by which scarce resources are allocated. That is the classic definition of politics. As such, the process of planning is far more than the mere development of technically competent plans, reports and analyses. Of at least equal importance is the development of a broad based community support for the process and for the specific policies which are embodied in the health systems and annual implementation plan.

Without broad public support, neither public nor private HSA's can withstand the political pressure which inevitably will result from policies aimed at making the health care system more efficient and effective.

There is clearly no large constituency now in existence for restricting the health care system. The some 50,000 responses to the recently issued National Guidelines for Health Planning make this absence abundantly clear.

Mr. ROGERS. May I interrupt. I am sure you are aware that some 43,000 came from three States. You may proceed.

Mr. GEMMELL. Thank you. If this constituency is to evolve, it must be developed at the local level and the HSA's are critically important participants. These local agencies must be credible and have the understanding and, hopefully, the support of all segments of the community which have an interest in improving the efficiency and effectiveness of the health care system.

Our concern is that elected officials and other major groups are alienated from the health planning process. Their alienation is caused by the structure and processes of many HSA's which are established to avoid the significant and meaningful involvement of the local official and other major consumer and provider groups. Yet, their involvement and political support are critical for the successful implementation of the plans and policies of the HSA.

The amendments we are proposing are based, in part, on intensive, on-site studies of some 15 HSA's around the country. They focus on assuring that elected officials and other major consumer and provider groups have a meaningful—as opposed to token—participation in the health planning process. While these changes will not assure community support, they will remove one of the major factors disintegrating such support.

First, we believe that the public regional planning body, joint powers agency or unit of local government should have the authority to approve the major policy documents of the agency, as well as the budget. It should also have the authority to set the rules and regulations of the agency and appoint the governing body for health planning.

Presently, after the governing body is appointed, the HSA has nothing to do. No wonder, Mr. Chairman, that local officials' attendance is sparse. Yet, it is responsible for the policies which are inherent in the HSP and AIP.

H.R. 10460 gives the governing board of the HSA the power to appoint the governing body for health planning and to approve the agency's budget. Budget control, we think, is critical and we fully support the inclusion of this provision. However, if the governing board is to be truly accountable and if the public agency is to play a truly meaningful role, then it must have the power to approve the HSP and AIP, the criteria for project, institutional and appropriateness review, set the operating rules and regulations for the agency and act as an appeal board for decisions made by the governing body for health planning.

A second major concern relates to the closed, often self-perpetuating nature of many HSA's. The present law allows a subcommittee of the

existing governing body to choose new members of the body. In addition, it allows virtually any member of a group to represent that group.

Therefore, any minority member can be deemed to represent minorities, an elderly person can represent the elderly, and so on. The problem of elected officials is particularly difficult. A public health nurse, a faculty member from a public community college in health sciences, or even the coroner can be considered a public official representing the county. A study of the first 136 HSA's showed that only 9 percent were local elected officials.

An additional problem, relatively unique to elected officials, relates to the need to clarify all governing body members as consumers or providers. Many elected officials are classified as providers solely because the county board also serves as the county health board, board of trustees of the county home or hospital or sponsors or funds programs providing county alcohol, drug abuse or mental health services.

However, elected officials are not providers as the act contemplated. They are public officials who represent the public. That is both consumers and providers.

While H.R. 10460 prohibits the selection of new members of the governing body by the existing governing body or a subcommittee of it, we believe that the bill should go further. Because of their significant role in the provision of health care, their role in paying for health care, particularly medicaid, and because they can show a direct constituency relationship to all segments of the community, we believe that one-third of the seats on an HSA governing body should be reserved for local elected officials or their designees from units of local government with substantial health interests.

We believe that elected officials should be identified as a separate category from consumers or providers. Local elected official seats should be filled by direct appointments by units of local government or combinations with substantial health interest.

Finally, there are 12 single State or virtually single State HSA's. In addition, there are several States, such as Iowa and Nebraska, with HSA's of 50 or more counties. In these areas and others, participation by local officials and others is difficult, if not impossible.

As a result, we believe that the act should contain a strong endorsement for subarea councils with the indication that where possible, they should follow existing, recognized boundaries. We also believe that the HSA's should be given the authority to delegate elements of plan development and project review authority to the subarea council.

In closing, on behalf of NACo, I would like to congratulate you and your staff for the fine job you have done in preparing H.R. 10460. We support many of the provisions already in the bill. That includes provisions allowing the secretary to return agencies which cannot perform to a conditionally designated status and provisions allowing increased rural representation.

It includes provisions significantly expanding open meetings and records requirements, requirements for public health and prevention expertise in HSA staffs, and provisions making area redesignations easier.

We are particularly pleased with the provision of $100 million for the refurbishment of public general hospitals. Many of the large, urban public general hospitals suffer from old and inadequate physical plants which are often in violation of health safety codes.

These amendments, and those we have offered, will go a long way to remedying the structural and procedural elements which have served to undermine local political support. With these changes, HSA's can become the strong, credible agents for change in the health care system that Congress intended.

Thank you.

[Testimony resumes on p. 530.]

[Mr. Gemmell's prepared statement and proposed amendments follow:]

STATEMENT OF MICHAEL K. GEMMELL, ASSOCIATE DIRECTOR, NATIONAL ASSOCIATION OF COUNTIES BEFORE THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, ON THE HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978, H.R. 10460, FEBRUARY 1, 1978, WASHINGTON, D. C.

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, MY NAME IS MICHAEL K. GEMMELL, ASSOCIATE DIRECTOR FOR HEALTH AND EDUCATION OF THE NATIONAL ASSOCIATION OF COUNTIES (NACo)[1] AND I AM HERE TODAY TO PRESENT OUR VIEWS ON H.R. 10460.

IN THE INTEREST OF TIME, WE ARE SUBMITTING FOR THE RECORD A DETAILED STATEMENT OF OUR PROPOSED AMENDMENTS TO THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT. I SHALL CONFINE MY REMARKS TO OUR MAJOR CONCERNS.

THE NATIONAL ASSOCIATION OF COUNTIES IS STRONGLY IN SUPPORT OF A TRULY LOCAL HEALTH PLANNING SYSTEM. THESE AGENCIES, WE BELIEVE, SHOULD PLAY A KEY ROLE IN THE CONTAINMENT OF COSTS AND THE IMPLEMENTATION OF A NATIONAL HEALTH FINANCING SYSTEM. THEY MUST ALSO PROVIDE THE STIMULUS FOR PROVIDING SERVICES IN UNDERSERVED AREAS AND ENCOURAGE THE KIND OF PUBLIC HEALTH AND PREVENTION ACTIVITIES WHICH OFFER THE GREATEST POTENTIAL FOR LONG TERM IMPROVEMENT IN HEALTH STATUS.

HOWEVER, PLANNING IN GENERAL AND HEALTH PLANNING IN PARTICULAR ARE INTENSELY POLITICAL ACTIVITIES. IT IS THE PROCESS BY WHICH SCARCE RESOURCES ARE ALLOCATED -- THE CLASSIC DEFINITION OF POLITICS. AS SUCH, THE PROCESS OF PLANNING IS FAR MORE THAN THE MERE DEVELOPMENT OF TECHNICALLY COMPETENT PLANS, REPORTS AND ANALYSES. OF AT LEAST EQUAL IMPORTANCE IS THE DEVELOPMENT OF A BROAD BASED COMMUNITY SUPPORT FOR THE PROCESS AND FOR THE SPECIFIC POLICIES WHICH ARE EMBODIED IN THE HEALTH SYSTEMS PLAN AND ANNUAL IMPLEMENTATION PLAN. WITHOUT BROAD PUBLIC SUPPORT, NEITHER PUBLIC NOR PRIVATE HSAs CAN WITHSTAND THE POLITICAL PRESSURE WHICH INEVITABLY WILL RESULT FROM POLICIES AIMED AT MAKING THE HEALTH CARE SYSTEM MORE EFFICIENT AND EFFECTIVE.

THERE IS CLEARLY NO LARGE CONSTITUENCY NOW IN EXISTENCE FOR RESTRICTING THE HEALTH CARE SYSTEM. THE SOME 50,000 RESPONSES TO THE RECENTLY ISSUED NATIONAL GUIDELINES FOR HEALTH PLANNING MAKE THIS ABSENCE ABUNDANTLY CLEAR. IF THIS CONSTITUENCY IS TO EVOLVE, IT MUST BE DEVELOPED AT THE LOCAL LEVEL -- AND THE HSAs ARE CRITICALLY IMPORTANT PARTICIPANTS. THESE LOCAL AGENCIES MUST BE CREDIBLE AND HAVE THE UNDERSTANDING AND, HOPEFULLY, THE SUPPORT OF ALL SEGMENTS OF THE COMMUNITY WHICH HAVE AN INTEREST IN IMPROVING THE EFFICIENCY AND EFFECTIVENESS OF THE HEALTH CARE SYSTEM.

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[1]NACo is the only national organization representing county government in America. Its membership includes urban, suburban, and rural counties joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving as the national spokesman for county government; acting as a liaison between the nation's counties and other levels of government; and achieving public understanding of the role of counties in the federal system.

OUR CONCERN IS THAT ELECTED OFFICIALS AND OTHER MAJOR GROUPS ARE ALIENATED FROM THE HEALTH PLANNING PROCESS. THEIR ALIENATION IS CAUSED BY THE STRUCTURE AND PROCESSES OF MANY HSAs WHICH ARE ESTABLISHED TO AVOID THE SIGNIFICANT AND MEANINGFUL INVOLVEMENT OF THE LOCAL OFFICIAL AND OTHER MAJOR CONSUMER AND PROVIDER GROUPS. YET, THEIR INVOLVEMENT AND POLITICAL SUPPORT ARE CRITICAL FOR THE SUCCESSFUL IMPLEMENTATION OF THE PLANS AND POLICIES OF THE HSA.

THE AMENDMENTS WE ARE PROPOSING ARE BASED, IN PART, ON INTENSIVE, ON-SITE STUDIES OF SOME 12 HSAs AROUND THE COUNTRY. THEY FOCUS ON ASSURING THAT ELECTED OFFICIALS AND OTHER MAJOR CONSUMER AND PROVIDER GROUPS HAVE A MEANINGFUL -- AS OPPOSED TO TOKEN -- PARTICIPATION IN THE HEALTH PLANNING PROCESS. WHILE THESE CHANGES WILL NOT ASSURE COMMUNITY SUPPORT, THEY WILL REMOVE ONE OF THE MAJOR FACTORS DISINTEGRATING SUCH SUPPORT.

FIRST, WE BELIEVE THAT THE PUBLIC REGIONAL PLANNING BODY, JOINT POWERS AGENCY OR UNIT OF LOCAL GOVERNMENT SHOULD HAVE THE AUTHORITY TO APPROVE THE MAJOR POLICY DOCUMENTS OF THE AGENCY, AS WELL AS THE BUDGET. IT SHOULD ALSO HAVE THE AUTHORITY TO SET THE RULES AND REGULATIONS OF THE AGENCY AND APPOINT THE GOVERNING BODY FOR HEALTH PLANNING. PRESENTLY, AFTER THE GOVERNING BODY IS APPOINTED, THE HSA HAS NOTHING TO DO -- YET, IT IS RESPONSIBLE FOR THE POLICIES WHICH ARE INHERENT IN THE HSP AND AIP.

H.R. 10460 GIVES THE GOVERNING BOARD OF THE HSA THE POWER TO APPOINT THE GOVERNING BODY FOR HEALTH PLANNING AND APPROVE THE AGENCY'S BUDGET. BUDGET CONTROL, WE THINK, IS CRITICAL, AND WE FULLY SUPPORT THE INCLUSION OF THIS PROVISION. HOWEVER, IF THE GOVERNING BOARD IS TO BE TRULY ACCOUNTABLE AND IF THE PUBLIC AGENCY IS TO PLAY A TRULY MEANINGFUL ROLE, THAN IT MUST HAVE THE POWER TO APPROVE THE HSP AND AIP, THE CRITERIA FOR PROJECT, INSTITUTIONAL AND APPROPRIATENESS REVIEW, SET THE OPERATING RULES AND REGULATIONS FOR THE AGENCY, AND ACT AS AN APPEAL BOARD FOR DECISIONS MADE BY THE GOVERNING BODY FOR HEALTH PLANNING.

A SECOND MAJOR CONCERN RELATES TO THE CLOSED, OFTEN SELF-PERPETUATING NATURE OF MANY HSAs. THE PRESENT LAW ALLOWS A SUBCOMMITTEE OF THE EXISTING GOVERNING BODY TO CHOOSE NEW MEMBERS OF THE BODY. IN ADDITION, IT ALLOWS VIRTUALLY ANY MEMBER OF A GROUP TO REPRESENT THAT GROUP. THEREFORE, ANY MINORITY MEMBER CAN BE DEEMED TO REPRESENT MINORITIES, ANY ELDERLY PERSON CAN REPRESENT ELDERLY, AND SO ON. THE PROBLEM OF ELECTED OFFICIALS IS PARTICULARLY DIFFICULT. A PUBLIC HEALTH NURSE, A FACULTY MEMBER FROM A PUBLIC COMMUNITY COLLEGE IN HEALTH SCIENCES, OR EVEN THE CORONER CAN BE CONSIDERED A PUBLIC OFFICIAL REPRESENTING THE COUNTY. A STUDY OF THE FIRST 136 HSAs SHOWED THAT ONLY 9% WERE LOCAL ELECTED OFFICIALS.

AN ADDITIONAL PROBLEM, RELATIVELY UNIQUE TO ELECTED OFFICIALS, RELATES TO THE NEED TO CLARIFY ALL GOVERNING BODY MEMBERS AS CONSUMERS OR PROVIDERS. MANY ELECTED OFFICIALS ARE CLASSIFIED AS PROVIDERS SOLELY BECAUSE THE COUNTY BOARD ALSO SERVES AS THE COUNTY HEALTH BOARD, BOARD OF TRUSTEES OF THE COUNTY HOME OR HOSPITAL, OR SPONSORS OR FUNDS PROGRAMS PROVIDING COUNTY ALCOHOL, DRUG ABUSE OR MENTAL HEALTH SERVICES.

HOWEVER, ELECTED OFFICIALS ARE NOT PROVIDERS AS THE ACT CONTEMPLATED. THEY ARE PUBLIC OFFICIALS WHO REPRESENT THE PUBLIC -- BOTH CONSUMERS AND PROVIDERS.

WHILE H.R. 10460 PROHIBITS THE SELECTION OF NEW MEMBERS OF THE GOVERNING BODY BY THE EXISTING GOVERNING BODY OR A SUBCOMMITTEE OF IT, WE BELIEVE THAT THE BILL SHOULD GO FURTHER.

- BECAUSE OF THEIR SIGNIFICANT ROLE IN THE PROVISION OF HEALTH CARE, THEIR ROLE IN PAYING FOR HEALTH CARE, PARTICULARLY MEDICAID, AND BECAUSE THEY CAN SHOW A DIRECT CONSTITUENCY RELATIONSHIP TO ALL SEGMENTS OF THE COMMUNITY, WE BELIEVE THAT 1/3 OF THE SEATS ON AN HSA GOVERNING BODY SHOULD BE RESERVED FOR LOCAL ELECTED OFFICIALS OR THEIR DESIGNEES FROM UNITS OF LOCAL GOVERNMENT WITH SUBSTANTIAL HEALTH INTERESTS.
- WE BELIEVE THAT ELECTED OFFICIALS SHOULD BE IDENTIFIED AS A SEPARATE CATEGORY FROM CONSUMERS OR PROVIDERS.
- LOCAL ELECTED OFFICIAL SEATS BE FILLED BY DIRECT APPOINTMENTS BY UNITS OF LOCAL GOVERNMENT OR COMBINATIONS WITH SUBSTANTIAL HEALTH INTEREST.

FINALLY, THERE ARE 12 SINGLE STATE OR VIRTUALLY SINGLE STATE HSAs. IN ADDITION, THERE ARE SEVERAL STATES, SUCH AS IOWA AND NEBRASKA, WITH HSAs OF 50 OR MORE COUNTIES. IN THESE AREAS AND OTHERS, PARTICIPATION BY LOCAL OFFICIALS AND OTHERS IS DIFFICULT, IF NOT IMPOSSIBLE. AS A RESULT, WE BELIEVE THAT THE ACT SHOULD CONTAIN A STRONG ENDORSEMENT FOR SUBAREA COUNCILS WITH THE INDICATION THAT WHERE POSSIBLE, THEY SHOULD FOLLOW EXISTING, RECOGNIZED BOUNDARIES. WE ALSO BELIEVE THAT THE HSAs SHOULD BE GIVEN THE AUTHORITY TO DELEGATE ELEMENTS OF PLAN DEVELOPMENT AND PROJECT REVIEW AUTHORITY TO THE SUBAREA COUNCIL.

IN CLOSING, ON BEHALF OF NACo, I WOULD LIKE TO CONGRATULATE YOU AND YOUR STAFF FOR THE FINE JOB YOU HAVE DONE IN PREPARING H.R. 10460. WE SUPPORT MANY OF THE PROVISIONS ALREADY IN THE BILL, INCLUDING:

- PROVISIONS ALLOWING THE SECRETARY TO RETURN AGENCIES WHICH CANNOT PERFORM TO A CONDITIONALLY DESIGNATED STATUS.
- PROVISIONS ALLOWING INCREASED RURAL REPRESENTATION.
- PROVISIONS SIGNIFICANTLY EXPANDING OPEN MEETINGS AND RECORDS REQUIREMENTS.

- REQUIREMENTS FOR PUBLIC HEALTH AND PREVENTION EXPERTISE IN HSA STAFFS.
- PROVISIONS MAKING AREA REDESIGNATIONS EASIER.

WE ARE PARTICULARLY PLEASED WITH THE PROVISION OF $100 MILLION FOR THE REFURBISHMENT OF PUBLIC GENERAL HOSPITALS. MANY OF THE LARGE, URBAN PUBLIC GENERAL HOSPITALS SUFFER FROM OLD AND INADEQUATE PHYSICAL PLANTS WHICH ARE OFTEN IN VIOLATION OF HEALTH SAFETY CODES.

THESE AMENDMENTS, AND THOSE WE HAVE OFFERED, WILL GO A LONG WAY TO REMEDYING THE STRUCTURAL AND PROCEDURAL ELEMENTS WHICH HAVE SERVED TO UNDERMINE LOCAL POLITICAL SUPPORT. WITH THESE CHANGES, HSAs CAN BECOME THE STRONG, CREDIBLE AGENTS FOR CHANGE IN THE HEALTH CARE SYSTEM THAT CONGRESS INTENDED.

THANK YOU.



NACo FACT SHEET: LEGISLATION

National Association of Counties
1735 New York Avenue N.W. Washington, D.C. 20006 202 785-9577

Proposed Amendments to The National Health Planning and Resources Development Act of 1974 (PL 93-641)

Resolution Concerning NACo Policy
on the Reauthorization and Implementation
of the National Health Planning and Resources
Development Act of 1974

Whereas, county officials must be intimately involved in the health planning process.

Whereas, counties provide many services to the medically indigent as well as public health and prevention services.

Whereas, Public Law 93-641 permitted HSAs to be formed without the active involvement of county officials.

Whereas, Some HSAs continue to exclude county officials from active and meaningful involvement in the planning and regulatory processes of the HSA. and

Whereas, Congress will be reviewing Public Law 93-641 late this year and must reauthorize the legislation by September 30, 1978.

NACo urges that:

- Congress extend the National Health Planning and Resources Development Act [P.L. 93-641] and reaffirm the principle that the primary responsibility for health planning must be at the local level.

- Congress act immediately to extend the maximum period of conditional designation for HSAs from 24 to 36 months.

- Congress mandate that a governor, state legislator and two elected officials representing general purpose local government be appointed to to the National Council on Health Planning and Development.

- Congress amend P.L. 93-641 to make HSAs more open and politically responsible:

  a) by permitting the redesignation of health service areas when a "more appropriate" area is identified and specifying that designations of any new health service areas should favor areas congruent with existing regional planning or council of government boundaries. Present law permits redesignation only when the existing area fails to make the legal requirement of P.L. 93-461.

  b) by requiring the Secretary to hold public hearings on area redesignation requests.

  c) by giving units of local government or combination thereof equal consideration for designation as health systems agencies in any future designation for redesignated areas or where the existing agency was terminated by HEW.

d) by giving the governing board of a public HSA authority to:

i) establish personnel and other rules and regulations for the agency, including the authority to hire and fire the executive director;

ii) review and approve or disapprove the health systems plan and annual implementation plan;

iii) review and approve or disapprove criteria pursuant to Section 1532; (project, new construction and appropriateness reviews);

iv) review and approve or disapprove the agency's yearly budget;

v) appoint the members of the governing body for health planning;

e) by requiring that at least 1/3 of the members of an HSA governing body and any executive committee be local elected officials or other representatives of general purpose local government directly appointed by a unit or combination of units of local government.

f) by exempting elected officials representing general purpose local government from the requirement that they be categorized as "consumers" or providers".

g) by changing the definition of rural area from non metropolitan to non urbanized and by requiring that the percentage of non urban representation be at least equal to the percentage of non urbanized residents in the health service area.

h) by stating that HSAs must form subarea councils or show cause why they fail to do so and by requiring that the HSA must delegate specific planning and review authority to them and by requiring that the composition of subarea council boards as closely as practical meet the composition requirements of Section 1521 (b) (3) (C).

i) by requiring that virtually all meetings of the governing body of an HSA as well as all meetings of committees, subcommittees and the executive committee be publicized and open to the public and that openness procedures comply with state "sunshine" laws when they are present.

j) by requiring that the HSA, in accordance with the AIP, provide technical assistance to prospective applicants.

k) by placing the area development fund in the State Health Planning and Development Agency and giving the HSA review and comment authority over proposed use of these funds.

l) by requiring that the HSA enter into formal agreements with units of general purpose local government or combinations thereof to assure that direct appointments of local governmental representatives are made; that adequate considerations is given to local comments on the HSP, AIP and annual renewal application and that a dispute settlement process exists.

m) by permitting the Secretary to return an HSA to a conditionally designated status if it fails to implement, in good faith, the structural requirements of Section 1512 and the planning and regulatory functions of Section 1513.

n) by requiring that the powers of any executive committee be formally delegated by the governing body for health planning.

. Congress fully fund HSA's at their authorized strength and raise in FY '79, '80 and '81 the authorization levels in order to cover inflation and increased authorities.

. Congress employ the existing local planning and regulatory structure in any cost containment program

. Congress specify public health and prevention as a required staff skill.

. Congress provide that 50% of all funds appropriated for facilities construction and renovation (Title XVI) be reserved for medical facilities owned by states, cities or counties.

. Congress adopt the Senate Amendment of Section 1625 in its approved version of H.R. 4975.

Adopted by the Health and Education Policy Steering Committee May 20, 1977

Proposed Amendments to The National Health Planning and Resources Development Act of 1974

The National Association of Counties strongly supports the concept of local health planning. We believe that health systems agencies should be given the authority to limit the growth of unnecessary medical facilities and equipment, to encourage the development of needed medical care in underserved areas and, most importantly, to encourage the kinds of public health and prevention activities which we believe have the greatest potentiality for improving health and reducing costs.

County and state health departments have long demonstrated that major improvements in health status can be achieved relatively cheaply through traditional, and in some cases less than traditional public health activities. We have seen a substantial reduction in infant mortality which can be associated with programs which provide care, attention and proper diet to pregnant women. There has been an appreciable reduction in the prevalence of lead poisoning due in part to lead based paint programs, often operated by state and local health departments. Other areas where potential benefits seem possible would be the reduction of stroke through the careful monitoring and control of hypertension; the reduction of heart disease and other diseases through conscientious programs to change the way people eat and exercise and the reduction in smoking; and the reduction of deaths which occur as a result of cancer of the uterine cervix through regular screening of women. In fact, it seems clear that the cause and most effective determinant of recovery in many forms of cancer relates to the environment and life style of the individual. In the long run, these kinds of programs can have a much greater effect on reducing the current level of illness and disease.

However, if local planning and local program development is to be successful, it must occur in an agency which is responsible to the desires of a local community. Free-standing, politically isolated agencies are bound to fail because of their inability to obtain feedback on the status of broad political support for their policies. In spite of the congressional intent to create an open process, the confused and complicated representational requirements in PL 93-641 allow a dominant faction in a private non-profit health systems agency to manipulate appointment process in such a way as to assure control. The result of this process (which has occurred in many, but by no means all of the private non-profit HSAs)is isolation, stagnation and eventual upheaval as necessary support groups become alienated from the planning agency.

NACo believes that this process of exclusion has been particularly significant with respect to elected officials. We have encountered many agencies which have permitted them minimal involvement and have been structured to assure that no legitimate influence external to the HSA can be brought to bear on the cecision making process.

Planning and the regulatory functions associated with HSAs are basically political processes since they define the criteria and process by which scarce resources are allocated. As such the elected local official is one of the only participants in the process who can demonstrate a direct relationship to a constituency; who is accessable to the public through a regularized and well understood process; and who can provide a perspective which is different from the narrowly defined interests and constituency, if any, of most "consumers" and "providers".

Thus, NACo feels that in its review of PL 93-641 Congress must more clearly identify realistic goals for the HSAs, must give them the tools necessary to plan for the improvement of health and limitation in the cost of medical care. Most importantly, it must assure that the health planning system is open and that significant interests including elected officials, have not only imput, but impact on local health policy decisions.

PROPOSED AMENDMENTS

I. The National Council on Health Planning and Development

Section 1503(b)(1)

> *The Council shall be composed of fifteen members. The Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of Health, Education, and Welfare shall be non-voting ex officio members of the Council. The Council shall include a governor, a member of a state legislature and two elected representatives of general purpose local government. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. ...*

State and local governments are significant providers of medical care and preventive care services. States provide financial input into the medicaid system, as do counties in 18

states. States and counties are the major provider of treatment services for the indigent and for persons suffering from alcoholism and drug abuse. In addition, they are the major source of public health, prevention and environmental health services. As such, these units of government provide a significant service and they bring a perspective to the planning process which is not paralled by the provider or consumer category. Therefore, they appropriately should be allocated specific seats on the body which is to advise the Secretary on the development of national health policy.

II. Area Redesignations

A. Criteria for redesignation

Section 1511(b)(4)

> *The Secretary shall review on a continuing basis and at request of any Governor or, designated health systems agency or units of general purpose local government the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a), or if a proposed health service area more appropriately or more completely meets the requirements of subsection (a), he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii). ...*

Particularly with respect to the west and the south, NACo has found a number of statewide HSAs which are difficult, if not impossible, to administer. In other areas there are also substate regions that may well prove to be inappropriate.

In Idaho, the HSA cannot maintain the staffing pattern which it feels is necessary and appropriate because of the heavy drain on its budget caused by travel expenses. Lack of funds and substantial weather problems make frequent meeting of the governing body impossible. In Mississippi, the single state HSA was imposed over three separate geographic regions and 10 regional planning units. There also continues to be agitation in some substate HSAs for area redesignation.

While NACo generally concurs in the belief that the modification of a health service area should be difficult and infrequent, we nevertheless believe that redesignation of areas should not wait until the existing area is in direct violation of Section 1511(a). Rather, we feel that when a substantially better

area is identified - one which has the support of the local communities, and the governor, then the Secretary should consider whether the area is more appropriate for health planning than the existing area. If it is a more appropriate area then redesignation should occur.

It is also clear that in some states, areas were defined in such a way as to exclude the possibility of public HSAs. Therefore, we believe that one of the critical criteria for consideration in redesignation should be that the area applying for designation is a unit of general purpose local government or a public regional planning body eligible for designation as a public HSA under Section 1512(b)(1)(B).

B. Procedures for Redesignation

Section 1511(b)(4) [new section]

> *The Secretary shall issue regulations indicating the criteria for area redesignation. In addition, for each requested area redesignation, the Secretary shall hold a formal hearing and shall issue a written decision in each case.*

NACo believes that the criteria for area redesignation should be clear and consistantly applied. Regulations have been published containing a statement of criteria [41 F.R.39433 (1975)].

However, the Bureau of Health Planning and Resources Development's policy in handling requests for area redesignation is to use ad hoc committees with only a set of minutes as the result of that process. This procedure gives no clarification to the criteria listed in the regulations.

NACo believes that the process of making decisions on area redesignations should help to clarify the criteria for redesignation - not obscure them.

In order to assure that decisions are rational and the criteria applied consistantly, the use of ad hoc committees should be eliminated. Rather, there should be a formal hearing. As a result of this hearing a written record should be developed with a finding of fact, a statement of the relevant statutory and regulatory language and HEW policy; a finding of facts and a decision.

III. Repeal Section Giving Priority in Area Designation to 314(b) Areas

Section 1511(c) [gives priority for area designation to areas which have a comprehensive plan prepared under Section 314(b) of Title III of the Public Health Service Act] *Repeal*.

This provision effectively excluded most counties and public regional planning bodies from being designated as health systems agencies. This provision, along with Section 1514, which authorizes the provision of technical assistance only to private non-profit applicants, has done much to create a feeling of animosity toward the legislation by elected county officials. Repeal of this section would help to indicate that Congress now believes that public and private applicants should be given equal assistance and consideration in any future redesignation resulting from the failure to renew the designation agreement of an existing agency or because of area redesignation.

IV. Including Public Health and Prevention Expertise as Part of HSA Staff

Section 1512(b)(2)(A)

Expertise - A health systems agency shall have a staff which provides the agency with at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii) health planning, (iv) development and use health resources, and (v) public health and prevention of desease.

Research conducted by the National Association of Counties Research Foundation indicates that many HSAs are focusing almost exclusively on medical care. Health of course, has little to do with medical care. Rather, it is a function of what we eat, drink, breath and the kinds of life styles we live. It is clear that we will neither improve health or reduce cost as long as HSAs continue the excessive emphasis on health care. Rather HSAs must take a broader perspective on health and the relation between health and medical care.

Therefore, NACo believe that Congress should also reaffirm its intent that HEW assure that approved Health Systems Plans contain aggressive and realistic goals in the area of public health and prevention.

V. Public Health Systems Agencies (Powers of the Governing Board)

Section 1512(b)(3)(A)

In general, a health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with subparagraph (C), which ~~shall~~ may have the responsibilities prescribed by subparagraph (B), and which ~~has~~ may have authority to perform for the agency the functions described in section 1513. The governing body of any unit of local government or regional planning unit which is a health systems agency shall have exclusive authority to:

i) Establish personnel and other rules and regulations for the operation of the agency including the authority to hire and fire the executive director.

ii) Review and approve or disapprove the Health Systems Plan and Annual Implementation Plan.

iii) Review and approve or disapprove criteria required pursuant to Section 1532 [project, institutional and appropriateness reviews]

iv) Review on appeal decisions made by the governing body for health planning under section 1513 e-h.

Section 1512(b)(3)(C)

A public regional planning body or unit of general local government which is a health systems agency may appoint the members of its governing body for health planning.

The Secretary, in developing the regulations for health systems agencies commented that "the relationship between these two bodies [the governing board and the governing body for health planning] has been one of the more controversial aspects of the implementation of PL 93-641." The Moss Amendment to PL 93-641 [Section 1513(b)(1)] was added to allow units of local government and public regional planning bodies to function as health systems agencies. Floor colloquies indicated that the governing body of the unit of local government or public regional planning body, which was an HSA (i.e. the governing board)should have the authority to set rules and regulations for the HSA, approve the annual budget and review and approve the health system plan and annual implementation plan and appoint and remove members of the governing body for health planning.

However, under the present regulations the governing board has little function except to appoint the members of the governing body for health planning. After appointment however, the

governing body for health planning is totally independent. As a result the governing body for health planning is not accountable to the governing board.

The result of these regulations has been to discourage the development of public HSAs because of the belief of local officials that they could not assure the accountability of the governing body for health planning. In some cases county officials have indicated to us that some private, non-profit HSAs give them more authority than they would have as governing board members of a public HSA. This interpretation serves to frustrate county officials: an effect which runs counter to the intent of PL 93-641 to foster cooperation among major constituent groups in the health service area.

The proposed amendment would re-establish the supervisory relationship between the governing body for health planning and the governing board. The intent of the amendment is to:

i) Allow the governing board to establish broad rules, including personnel, on how the HSA operates.

ii) Allow the governing board to review the major policy documents and to review specific decisions which raise broad policy questions. These amendments, we believe implement the intent of Section 1512(b)(1).

VI. Number and Method of Appointment of Local Governmental Representative to the Governing Body for Health Planning

Section 1512(c)(1)(i) [*new section*]

At least one third [of the members of the governing body and any executive committee] shall be public elected officials or other representatives of general purpose local government. To be considered a "representative" an elected official or other individual must be directly appointed to the HSA governing body. Elected officials shall be considered as a separate category and the requirements of paragraph (ii) and (iii) percentage of consumers and providers shall not apply to elected officials representing general purpose local government.

Section 1512(c)(2)(C)(iii)

Repeal [present section dealing with elected officials]

A. Method of Appointment

One of the most vocal concerns expressed by county officials with whom we have had contact has been the failure to obtain direct representation on HSA governing bodies for health planning. Often local elected officials or other governmental representatives constitute a small percentage of the governing body. Persons designated as "representatives of local government" have been appointed without the knowledge or consent of local government. The problem, of course, is one of definition and extends well beyond elected officials. Simply stated, it is clear that because an individual is a member of a group - local elected officials, physicians, hispanics, etc. - that individual has no inherently legitimate claim to represent that category. It is clear that the congressional intent was to represent local government on the HSA governing body and the executive committee. However, the notion of "representation" has been lost in the implementation of the Act. Most HSAs have fallen into the practice of calling elected officials (and other) "representatives" of a group or groups merely because they are members of the group. Thus, an HSA, with HEW blessing, will consider a black, female elected official as a representative of blacks, women and the local governmental unit to which she was elected.

This tendency is quite understandable given the difficult if not impossible composition requirements for the governing body for health planning in PL 93-641. However, the result of this practice has been virtually to eliminate the possibility that local government and other interests have legitimate and responsible representatives on the governing body.

Many HSAs employ a system which insures that the existing governing body of a private non-profit HSA or a subcommittee of it, has final authority over membership. This is not accountability. Accountability, outside of election, can only come through the direct appointment of (and authority to remove) "representatives" who will represent the interests of a constituency. It is only through this method that external interests can have impact on the HSA governing body structure and the policies of the HSA.

B. Number of Local Governmental Representatives

In addition to the way in which elected officials and other representatives of general purpose local government are defined and selected, NACo is concerned about the number of local governmental representatives on HSA governing bodies. A study by the Bureau of Health Planning and Resources Development of 136 HSAs dated September, 1976 indicated that local elected officials constituted about 9% of the members of HSA governing bodies for

health planning. An additional 6% were categorized as "public officials" although the definition of this term and the degree to which these individuals represent local government is, at best, unclear.

NACo believes that elected officials representing general purpose local government must have increased participation in private, non-profit HSAs. Local elected officials are politically responsible. Planning is basically a political activity since it acts to identify needs, define those needs in the context of scientific findings and allocate scarce resources to each need. If this political process is to have legitimacy and, more importantly, receive necessary feedback from those unorganized and less articulate members of the community, then increased local elected officials involvement is crucial.

Therefore, we believe it is imperative that local elected officials and other representatives of general purpose local government compose at least 1/3 of the members of the governing body for health planning and any executive committee.

C. Classification of Elected Officials as "Consumers" or "Providers"

One area which we found substantial variation among the federal regions, accompanied by a lack of any rational policy has been the classification of elected officials. Many elected county officials have ex officio roles on policy making boards of publicly supported institutions providing health care and public health services. The county board is often the county health board, the board of directors of the county hospital or county home, the board of trustees of the county community colleges, etc. Often, too, elected officials sit as ex officio members of various public health and hospital boards which contain elected and non-elected officials. Counties often operate health programs funded by state and federal agencies as well as from local funds.

Yet, elected officials do not fall in the same category as other consumers or providers that sit on similar boards. They alone have the legitimacy of having stood for election. They are representative of both the consumer and the provider.

However, there is a difference in interpretation among the federal regions as to whether an elected official is per se a consumer or provider and which ex officio functions, if any, can change that status. In some regions for example, the role of the county board and the definition of provider by the region

has resulted in all elected officials being categorized as providers. Thus, they must find positions within the 40-49% of the governing body allocated to this group. As a result, their presence must often be substantially reduced because of the legitimate demands for representation of more clearly identified provider groups.

County officials have been recognized by Congress and the courts as part of our federal system of government. As such, the units of local government they represent do not constitute a private interest. Rather they represent the public interest. Given this unique status, NACo proposes to exclude them from the consumer/provider category and create a separate elected official category.

D. Summary

In summary, we believe that Section 1512(b)(3)(c)(1) should be amended to require at least 1/3 of an HSA governing body be appointed directly by units of general purpose local government with substantial health interest*. Furthermore, we believe that HSAs should not be required to categorize elected officials as consumers or providers. Rather they should be considered a third category with only other, non-elected individuals being required to meet the consumer/provider formula.

VII. Powers of the Executive Committee

Section 1512(b)(3)(A)

> *...Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an "executive committee composed, in accordance with subparagraph (C), of not more than twenty-five members of the governing body ~~and has delegated~~. The governing body may*

*No simple rule of thumb or catch phrase will define appropriate units of general purpose local government. The vast diversity of structural arrangements of local governments which have evolved in relation to peculiarly local conditions makes universal definition difficult. This report will not attempt to specify appropriate units.

delegate to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

Under the present law, a governing body for health planning must delegate all authorities (other than to establish and review the HSP and AIP) to the executive committee. As a result, for such activities as project review, 1122 and certificate of need review and appropriateness review, the executive committee can act in lieu of the full body and the governing body cannot review or reverse the executive committee. The executive committee becomes, under this legislation, the equal of the full governing body rather than its subordinate.

NACo believes that it is advisable to keep the size of the governing body below 30. However, if a larger governing board is required, then we believe that a strong executive committee should be established. However, we believe that the powers of the executive committee should be set by the governing body itself and not by congressional mandate.

VIII. Rural Representation

Section 1512(b)(3)(c)(iii)(II)

Include a percentage of individuals who reside in ~~non metropolitan~~ non urban areas within the health service area which percentage is at least equal to the percentage of the area.

Congress in its final deliberations on PL 93-641 became concerned that rural areas would be under-represented on HSA governing boards and bodies. In order to avoid this problem and to insure participation by rural areas, Section 1512(b)(3)(c)(iii)(II) was added. However, rather than acting as a floor for participation by rural interests, this provision has placed a cap on their involvement. In two California HSAs, HEW is requiring a reorganization of the governing body because of too many rural representatives in spite of the fact that the composition represents a consensus of both urban and rural representatives.

Local areas must develop a means of accommodating non-urban interests when there is a large metropolitan county surrounded by rural areas. Often, these accommodations may over-represent rural areas yet are satisfactory to both rural and urban counties. In fact in mixed areas the urban representatives predominate even when rural interests are over represented.

There is often a strong push in the HSA to have at least one representative from each county. This pattern is often used in other areawide agencies. The effect of this effort, coupled with the "equal to" provision results in huge governing bodies. Any attempt to limit the governing body for health planning to a reasonable size results in a denial of membership to some rural areas. More importantly, it represents yet another point of friction between rural and urban areas and can disrupt the development of the HSA.

NACo believes that a review of the background of the "equal to" provision would indicate that the congressional intent was to create a floor to encourage rural participation.

Therefore we propose to amend the "equal to" provision to read that, at a minimum, the urbanized/non-urbanized mix should equal that of the area. However, we also believe that any rural representation beyond the minimum must represent the consensus of both the urban and rural areas.

Also, it seems clear that the Standard Metropolitan Statistical Areas which are used to define the metropolitan area do not adequately separate rural and urban areas. The designation as part of an SMSA has become subject to political pressure and often the SMSA includes rural, underserved areas. As a result, NACo believes that the criteria should be changed from metropolitan/non-metropolitan to urbanized/non-urbanized areas which are existing census definitions.

IX. Open Meetings and Records

Section 1512(b)(3)(B)(viii)(I-III)

> *I) Except for confidential meetings called to discuss the performance or remuneration of individual HSA employees, all meetings of the HSA governing body or executive committee, and any subarea council, committee or subcommittee meetings must be open to the public and held with full notice to the public of such meetings, II) adequate public notice of meetings must be provided, including dissemination through newspapers, radio, television and mailing lists of interested individuals, III) all records, excluding only personnel records and data on individual staff members, must be open to the public and available upon request.*

HSAs, be they public or private, perform functions which are essentially public in nature. The public's business should be conducted in the public eye. Sometimes, the eye needs to be

propped open. When the public does not show interest or care to participate in HSA activities, this often means that it has not been adequately informed about those activities. HSAs have a responsibility to keep their public informed.

The process which NACo proposes for the public review of agency designation applications, HSPs and AIPs covers only a few key HSA functions. Even so, we suggest only the most skeletal elements required for accountable public review in that process. In a more far reaching sense, the public--including the representatives who are elected to govern in the public's behalf--also needs to be involved in the routine activities of the agency. This requires that special efforts be made to assure that ordinary private citizens, public officials, and individuals and groups who can reasonably be presumed to have a special interest in any particular activity, feel that this activity is accessible to their participation.

HSAs are required to meet on a regular basis and to advertise their meetings. We have found, though, that the meeting schedule is sometimes irregular and that the advertisements consist of ads in the legal notices sections of newspapers. In addition, meetings are often held in places which are too small to accommodate an audience, or at inconvenient times or locations. Moreover, opportunities for the public to address these meetings tend to be very carefully limited and controlled.

We believe that this provision must be strengthened because examples which have come to our attention of violations of the intent of the current provision. NACo has had county officials tell us of applicants being excluded from project review meetings at which their proposal was discussed.

Therefore in this provision we propose to require the HSA to undertake an active program to inform the citizen of the activities of the agency. These would include broad publication of all HSA meetings, use of mailing list of interested individuals, use of many meeting sites in large HSAs, etc.

X. Subarea Councils

Section 1512(c)

A health systems agency ~~may~~ should establish sub-area ~~advisory~~ councils representing part of the agency's health service area to advise the governing body of the agency on the performance of its functions and to carry out any function with respect to the sub-area delegated to it by the governing body, and to carry out planning and other

advisory duties assigned to it by a unit or units of general purpose local government within the subarea. Sub-area councils should follow existing neighborhood, local governmental or regional configurations. The composition of a subarea ~~advisory~~ council shall, to the extent practicable, conform to the requirements of subsection (b)(c)(3).

Planning is a decision-making process - hopefully rational - which defines and assesses needs and allocates scarce resources to meet them. It is political process. As such, NACo believes that the establishment of the planning process must be maintained as closely to cities and counties - and to a lesser extent A-95, comprehensive planning and councils of governments regions - as possible. At these levels, political institutions exist which have a developed mechanism for the input of a broad base of views and a political accountability of those who make decisions.

Health service areas were defined through a process, and with statutory restrictions, which resulted in many large health service areas. There are 12 statewide or virtually statewide HSAs. In addition, there are a substantial number of HSAs which combine large metropolitan areas with rural areas that have different sets of problems and needs. Core areas in inner cities also have different health needs and problems.

In the single HSA states, we found that elected officials (and others) from rural areas had severe problems even getting to meetings.

In the vast majority of substate health service areas, the differences in needs, cultural heritage and perspectives between rural and urban areas, and among communities within the urban area, are not being addressed.

NACo believes that the best approach, short of redesignation, is to create a strong subarea council system. These smaller geographic units, hopefully attached to an existing entity - are critical methods for coalescing and articulating the divergent interests which exist within a health service area. These agencies can provide a significant input into the many functions of the HSA and we recommend that HSAs be given the authority to delegate functions to the subarea where appropriate.

We also believe that subarea councils will, (and should) become local agencies to which local government will turn for assistance in health related decisions. These decisions might include advice on zoning decisions by a city council or county board of commissioners, studying how a county health department or a consolidation of city and county health department can be established,

planning for a rural health care system under the broad umbrella of the HSP, etc. The development of these function is important to the improvement of the decision-making process and to improving the coordination of all health related planning activities in the community.

Finally, NACo believes the present requirements that the subarea council board meet the same representational requirements as the governing body for health planning is too stringent and retards the development of subarea councils. In rural and inner city areas, it is often difficult to get the required number of providers. Requirements of income mix are similarly difficult to meet in some areas. Therefore, NACo recommends that the composition requirements indicate that subarea councils must meet as closely as possible the formula established in Section 1512 (b)(3)(C) but if their situation is such that meeting the requirements is impossible or inappropriate, then certain requirements can be waived.

XI. Requirements for Technical Assistance

Section 1513(C)(2)

> *The Agency may must provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and private agencies for the development of projects and programs...*

County officials and various providers have indicated to NACo that there have been instances where projects have been turned down solely because of technical flaws in the proposals. Comments from some HSA staffs have indicated that they feel that extensive technical assistance to applicants would compromise the regulatory function of the HSA. NACo does not agree.

The regulatory function of HSAs should be secondary to their planning and developmental functions. Used creatively, regulation and review can be a tool for achieving results which would otherwise not be accomplished. Effective use of HSA authorities could lead to the harmonious development of a systematically organized and structured health care system.

HSAs should establish cooperative, rather than adversary, relationships with community service providers. In their role as referees, HSAs can help provider entities to define their own unique missions and work cooperatively to provide services which achieve the long range goals established in the HSP. The principal means by which this can be established is through negotiation in a trusting environment. Among the best mechanisms for the development of trust is the experience of cooperative planning and development.

This proposed amendment, then, will require the HSA to provide technical assistance to providers to insure that needed and appropriate services identified in the HSP and AIP are established.

XII. Area Health Services Development Fund

Section 1513(c)(3)

(3) The Agency shall, in accordance with the priorities established in the AIP, ~~make grants to public and non-profit private entities and enter into contracts with~~ solicit proposals from individuals and public and non-profit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. The proposals shall be submitted with the agency's review and recommendations to the state health planning and development agency.

NACo believes that distribution of funds is an inappropriate function for regional bodies, particularly one which is, to date, so far removed from local government. The American County Platform states that regional bodies shall not allocate funds.

This policy is based on our strong belief that the final allocation of tax monies is one of the most politically sensitive functions of government. The allocation of these funds is not a function of any regional or multi-jurisdictional entity - no matter how many elected officials participate. This function must remain with federal, state or local government and, in this case, we believe it should be a state function.

Therefore, the amendment of this section would place a review and comment function in the HSA with a final funding decision lodged with the state.

XIII. Relations Between HSAs and Units of Local Government

Section 1513(e) [new section]

Each health system agency shall enter into formal written agreements with units of general purpose local government or, in large HSAs, with existing combinations of units of governments. Such agreements shall include:

a) the number of appointments and the process for making direct appointments to the governing body for health planning.

b) *the method and schedule for review by the local government or combination thereof, of the HSP, the AIP, the agency's application for refunding and other appropriate policy documents.*

c) *the process by which suggested changes will be included in review documents and how disputes between the HSA and units of local government will be resolved.*

Under the present legislation, HSAs can function without the meaningful involvement of local government. The HSA can be established so as to virtually exclude the meaningful impact of the views of elected officials. Self selection of governing body members can virtually isolate the HSA from any local impact through its governing body selection process. In addition, A-95 reviews generally are ignored with impunity.

Elected county officials are critical participants in the planning and implementation process. Local governments:

- Provide most of the public health and environmental health activities in a community.
- Provide care to the medically indigent.
- In 18 metropolitan states, share in the costs of medicaid.
- Often must fund new programs when federal seed money expires and third party payments are either unavailable or insufficient.
- Provide mental health, mental retardation, alcoholism and drug treatment and services.

In order to increase the involvement and impact of local officials, we propose that HSAs be required to establish formal written agreements with units of local government. Where there are a large number of municipalities and counties in a health service area, we believe that area redesignation should be considered.

However, in areas with sparce population, we believe that formal agreements with regional planning bodies, councils of government or other regional units and the major units of local government is an acceptable substitute.

NACo believes that it is critical that formal and binding agreement exist between local government and HSAs. It is only through procedures such as these that any guarantee of continued HSA accountability can be assured.

XIV. Equal Treatment For Units of Local Government or Combinations in Any Agency Redesignations.

Section 1514 [providing technical assistance for designation only to private non-profit agencies] *Repeal.*

Section 1514 [new section]

The Secretary shall provide all necessary technical and other non financial assistance (including the preparation of prototype plans of organization and operation) to any potential applicant for designation as a health systems agency which results from the denial of a renewal application or the redesignation of a health service area. Equal consideration and assistance shall be given to units of general purpose local government or combination thereof for designation under section 1512(b)(B and C) as is given to all other applicants.

HEW, acting under what it believed to be Congressional intent, gave extensive assistance, including flexibility in using holdover funds from predecessor agencies, to the private non-profit agencies that had been 314(B) agencies. Priority for designation was given to these agencies, even though they were far from successful.

The discrimination against local government, the roadblocks, the delay and, occasionally, the outright subversion of potential public HSA applications went a long way to create animosity toward PL 93-641 by county officials.

We believe that at the very least, Congress should repeal section 1514 which opened all doors for private non profit agencies, but provided little, if any to potential public HSAs. As a result of this policy there are only 23 public HSAs.

We also believe that in any redesignation due to failure of the existing HSA or area redesignation, potential public HSAs be given equal assistance and consideration on the merits of the application.

XV. Extension of Period of Conditional Designation

Section 1515(a)(2)

During any period of conditional designation (which may not exceed 24 36 months)...

Before September 30, 1978, 196 HSAs which are now conditionally designated will apply for full designation. At that time HEW will have no middle ground between granting a full designation to an agency that meets very minimal standards or withdrawing the designation completely and reopening competition in the health services area.

In its initial review of the health service plans of the few agencies applying for full designation, HEW has found none that meet minimum qualifications. In fact, the quality of the first plans raised questions as to whether any but a handful of HSAs can produce an adequate health systems plan within 24 months.

NACo also feels that implementation of many of the requirements in the present law, (and the amendments proposed in this package) has been slow and continued progress requires HEW to maintain the increased supervision of a conditionally designated status.

Therefore, to give the HSAs additional time to meet the requirements of PL 93-641 and to continue the close scrutiny by HEW, we propose to extend the period of conditional designation from 24 to 36 months. Since this amendment cannot wait for full reauthorization, we propose that congress immediately pass an amendment to PL 93-641 to affect this change.

XVI. Provision for Return to Conditional Designation for Non Performing Agency.

Section 1515(e) [new section]

If, upon review by the Secretary of the Agency's renewal application, he finds that the agency has failed to carry out the requirements of Sections 1512 and 1513, he must return the Agency to a conditionally designated status for a period not to exceed 24 months. Such a change in status can only occur 90 days after formal notice has been given to the Agency.

NACo believes that the sanctions open to the Secretary should provide more options than the extreme option of not renewing the

designation agreement. Generally speaking, political pressures effectively prohibit the use of such severe sanctions. As a result, there is virtually no way in which the Secretary can force good faith compliance with the requirements of Section 1512 and the improvements in functions carried out under Section 1513.

The proposed amendment would allow the Secretary to impose the restrictions and additional control of conditional status on agencies which fail to implement in good faith Section 1512 and 1513. It provides a middle ground and avoids the extreme of totally eliminating, over a short time, the planning function within an area. If at the end of the 24 month period, the agency still is unable to perform, it can be terminated by the Secretary.

XVII. Funding and Match

Section 1516(b)(1)

The amount of any grant under subsection (a) to a health systems agency designated under section 1515~~(b)~~ shall be determined by the Secretary ~~the amount of grant under subsection (a) to any health systems agency designated under section 1515 (c)~~ and shall be the lesser of:

(A) the product of ~~$0.50~~, $0.55 during the fiscal year 1979. $0.60 during the fiscal year 1980, and $0.70 during the fiscal year 1981 and the population of the health service area for which the agency is designated, or "(B) ~~$3,750,000~~, $4,500,000, unless the agency would receive a greater amount under paragraph (2) or (3).

Section 1516(b)(2)(B)

The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall:

"(i) not include any funds contributed to the agency by an individual, association, insurors, or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or operation of health resources of the kind that may be within the purview of the agency's function under subsections 1513(e), (f), and (g) and

"(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without

conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used."

"(3) The amount of a grant under subsection (a) to a health systems agency designated under section 1 ~~1515(a)~~ may not be less than ~~$175,000~~, $185,000 during the fiscal year 1979, $195,000 during the fiscal year 1980, and $205,000 during the fiscal year 1981."

This provision would raise the authorization level of funding for HSA activity. It would encourage that the amount awarded increase from $.50 per capita, to $.55 in 1978, $.60 in 1979, and $.70 in 1980. In addition the maximum grant is raised to 4.5 million and the minimum raised from $175,000 to $185,000 in 1979, $195,000 in 1980 and $205,000 in 1981.

The health systems agency will be performing significant new authorities in the coming years. NACo, of course, is seeking changes to make them more accountable. However, even if we were to be completely successful, HSAs would have a difficult time because of limited staff.

If HSAs are to carry out their existing planning and regulatory functions, they must have adequate staff. The Carter Administration's cost control proposals will, if enacted, add significant new authorities to the HSA. Full funding, up to the level of proposed authorizations would, we feel, provide adequate funding for HSA activities.

In addition, we have proposed to raise the minimum grant to predominantly rural HSAs. These funds, we believe, will help develop core staff and subarea council staff to encourage the participation of rural elected officials and others in the health planning process.

XVIII. HSA Budget Review by the Secretary

Section 1535(a)

The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 1524(c)(3) and the comments of units of general purpose local government within the health service area.

NACo feels that the A-95 review function has been marginally effective, at best. Counties tell us that HSAs as well as HEW ignore their comments with impunity. NACo believes that in the face of this ineffectiveness, PL 93-641 should be amended to insure that it contains adequate provisions for review of local governmental comments by the Secretary. In line with this overall policy, we believe that Section 1535(a) should be amended to require that the Secretary to consider the comments of local government in his review of HSA budgets.

XIX. Funds for Renovation of Public General Hospitals

Section 1613

> *Except as provided in section 1625(d), there are authorized to be appropriated for allotments under section 1510 $140,000,000 for the fiscal year ending September 30, 1979, $145,000,000 for the fiscal year ending September 30, 1980 and $150,000,000 for the fiscal year ending September 30, 1981.*

Section 1625(a)

> *[Project grants for upgrading public medical facilities] (d) of the sums appropriated under section 1613 for a fiscal year, there shall be made available under subsection (a) for such fiscal year 50 percentum of such funds.*

Three out of ten hospitals in this country are owned by state or local government. Often these hospitals provide access to care for those who are unable to utilize private facilities due to geographic or social barriers. In the large urban area the public general (often county) hospital has had the historic function of serving the poor. In some states the county is mandated to provide this service. In rural areas, the public general hospital often provides exclusive service. In fact, over 40% of all rural hospitals are publicly operated.

In addition to their different clientele, the public general hospital also provides a somewhat different array of services. Often, they are the only hospital to willingly accept alcoholism and drug abuse cases. A recent study of large urban hospitals also indicated that they provide three times more out-patient services relative to their inpatient workload than the average community hospital of comparable size. In the rural areas, they are a major source of primary care.

This mix of services has caused serious financial problems for the public general hospital. The patient in urban public

general hospital are the most poor and most seriously ill. Third party payment often fails to meet expenses and the local governmental tax base provide the resources to fill this gap. Rural public and other general hospitals suffer from third party payment rates which are lower than urban rates.

The financial problems problems of local government makes it difficult to raise capital for reconstruction or renovation of the public general hospital. Tax revenues cannot meet their need and localities often must borrow at extremely high interest rates. In some cases, localities are excluded from the bond market altogether. Often the physical plant is old and renovated only with extreme difficulty, yet renovation is required if the hospital is to meet life safety codes. Public funds deriving from sources other than the property tax is critical to the upgrading of the public general hospital.

Finally, it is often noted that there are an excessive number of beds, primarily concentrated in the urban areas. NACo, agrees with this finding and supports strong controls on construction and renovation. However, the services provided by the public institutions. We believe that as a result of these differences, generalizations on bed limitations do not necessarily apply to publically operated institutions. We believe that the review of proposed renovation or construction of public general hospital beds or other facilities should take into account the specialized services of the institution. If the proposed construction is needed, then federal funds should be available to finance it.

Mr. ROGERS. Thank you very much for your statement and the general support of the association of counties and for the suggestions. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. Chairman, I have been the ranking member most of the time I served on this subcommittee with you. I do not believe we have let political considerations enter into this process.

I note you state that this is an intensely political activity and you feel that elected officials should be involved to the entent of 30 percent. As I see it, there is no way that they should control the health system agencies.

Mr. GEMMELL. Dr. Carter, our statement is trying to indicate that whatever the HSA's develop in terms of plans and policies that those plans and those policies be reflected in terms of cost containment, allocation of resources, correction of maldistribution problems, and that those decisions, in order to be fully carried out, must have the support of all of the community, including elected officials.

This is not a power move on the part of the National Association of Counties.

Mr. CARTER. All sections of the community, and especially elected officials, is that correct?

Mr. GEMMELL. Dr. Carter, we stand on the record. One-third of the governing body should be elected officials or their designees. They should not come out of the provider or consumer side, Doctor.

Mr. CARTER. Let me tell you of an experience; and I spoke to the chairman about this a few days ago. It was my good fortune to be a member of a group which helped to build a hospital with Hill-Burton assistance. We opened that hospital many years ago. The county attorney in the county where this hospital was built happened to be in the area. He told us: "I don't want a thing to do with that hospital. We are going to let you fellows lease it at $1 a year and let the trustees run it without any influence from this county."

I tell you, my friend, that that hospital ran very well. No politics was involved—none whatsoever.

Some time later another person, who was not so enlightened, got into this position and he took it over. You talk about a political mess; it became just that.

It is my feeling, sir, that you now have 15 percent county officials, according to your statement, on the HSA boards. I consider that that is sufficient, and that that is good representation. But to say that you should control the HSA board would really contradict the purpose of this bill and divorce HSAs from the people.

It is my feeling that we have many public-spirited citizens around our country, good people, who want to see the right thing done. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much.

Actually local public officials, depending on their duties, could be considered either as providers or as consumers and, if they were involved in official duties as providers of services in their official capacity, probably they would not be considered as providers. So a possibility of their having a major input is provided.

Now, it is my understanding that you feel that local government should have the authority to approve major policy documents of the agency as well as the budget.

Mr. GEMMELL. In the public HSA's; that is correct, Mr. Chairman.

Mr. ROGERS. For instance, in my area there are five counties in our HSA. Which public body would approve that?

Mr. GEMMELL. Mr. Chairman, this requirement of approval of policies and the rules and regulations applies to only 20 or so public HSA's that exist in the country. We are not imposing these changes on private HSA's. Most of the public agencies have a joint powers agreement where all the five counties have one board of elected officials to make these decisions.

Mr. ROGERS. We certainly will go over your recommendations carefully. We appreciate your being here. Thank you so much for your testimony.

Mr. GEMMELL. Thank you, Mr. Chairman.

Mr. ROGERS. The next witness will be Mr. Bert Seidman, director of the Department of Social Security, AFL-CIO. He is accompanied by Richard Shoemaker and Robert McLaughlin. Welcome to the committee. Your statement will be made a part of the record [see p. 534]. You may proceed as you wish.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS (AFL-CIO), ACCOMPANIED BY ROBERT MC GLOTTEN, LEGISLATIVE REPRESENTATIVE, DEPARTMENT OF LEGISLATION; AND RICHARD SHOEMAKER, ASSISTANT DIRECTOR, DEPARTMENT OF SOCIAL SECURITY

Mr. SEIDMAN. Thank you, Mr. Chairman. As you have indicated, with me this morning are Mr. Robert McGlotten, legislative representative in the Department of Legislation of the AFL-CIO, and Richard Shoemaker, an assistant director in the Department of Social Security of the AFL-CIO.

Mr. Chairman, it gives me great pleasure to appear before this subcommittee today. As you know, Mr. Chairman, we have supported health planning in the past and expect to do so in the future.

Many amendments to the health planning law have been proposed by many organizations, among which are those proposed by the Consumer Coalition for Health. This coalition developed out of the Consumer Conference on Comprehensive Health Planning last June, at which you were the keynote speaker. We thank you, Mr. Chairman, for having made a significant contribution to this conference which resulted in the formation of the consumer coalition. This coalition will play an important role in achieving effective consumer participation in the health planning process.

The AFL-CIO opposes any major structural modification in the planning law at this time. Not even all of the regulations have been promulgated. Only a handful of health systems agencies—HSA's—

are fully designated. Any major structural changes such as the Governors or the counties are proposing would mean further delays in implementing the law. Planning should be given an opportunity to work.

The labor-management group on which AFL-CIO president George Meany and General Electric president Reginald Jones serve as co-chairmen has adopted specific recommendations with respect to health planning, health maintenance organizations and prospective reimbursement of hospitals. These position papers are attached in appendix A [see p. 543].

Mr. Rogers. They will also be made a part of the record.

Mr. Seidman. Thank you, Mr. Chairman.

Labor and management agree that both should be represented at all levels of planning as major purchasers of care through the collective bargaining process and as consumers.

Consumer representatives on health planning agencies have many handicaps in bringing their influence to bear on the health planning process. For instance, they must review voluminous proposals on their own time while providers can do this as part of their job. Consumers therefore need technical assistance and training. Also, planning decisions affect providers very directly but consumers indirectly. At any given meeting, therefore, providers usually outnumber consumers. To achieve equity, therefore, consumers should comprise 60 percent of health planning bodies.

One of the major deficiencies of the present planning law and of the present renewal bill, H.R. 10460, is that only need is used as a criterion for determining whether a capital expenditure can be made for a health facility. Not all capital expenditures increase health care costs. Some reduce costs. Cost effectiveness as well as need should, therefore, be considered by planning agencies in determining whether new equipment or a new facility should be built.

Congress has adopted two strategies for containing health care costs. The Planning Act adopted a strategy of regulation. The Health Maintenance Organizations Act adopted a strategy of competition. There is no reason why both strategies cannot be adopted at the same time. Unfortunately planning in some instances is interfering with the development of health maintenance organizations. Eight case histories illustrating the problem are attached as appendix B [see p. 557].

The AFL-CIO strongly recommends to the Congress that this conflict between planning and HMO development be resolved. In our detailed testimony we indicate how we think this can be done.

Let me now briefly comment on some specific provisions of the bill, and we have more detailed comment on each of these provisions in the full statement.

First, we believe the planning law should be renewed for 3 years and not just one. Cost effectiveness should be added wherever the word "need" occurs in the statute. Blue Cross, Blue Shield and insurance companies should be prohibited from making contributions to HSA's, as is the case in present law. Both labor and management should be represented at all levels of the planning process. Nonpro-

fessional employees should be represented on HSA's as well as professionals as providers of care. Board members of HSA's should be reimbursed for expenses incurred for attending meetings. State planning agencies should develop their overall State plan from the local plans submitted by the HSA's in the State.

State programs to close facilities should provide severance pay and/or reemployment for laid-off employees. Construction grants and loans should be made available to PPGP's as well as to the other grantees mentioned in section 301 of H.R. 10460.

Other sections of H.R. 10460 which we have not specifically mentioned have our support or neutrality.

We hope that the Congress will act as quickly as possible on this legislation with due consideration to the improvement we have suggested.

[Testimony resumes on p. 584.]

[Mr. Seidman's prepared statement and attachments follow:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE HEALTH SUBCOMMITTEE
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE
ON THE HEALTH PLANNING AMENDMENTS OF 1978

February 1, 1978

Mr. Chairman, it gives me great pleasure to appear before this subcommittee today. As you know, Mr. Chairman, we have supported health planning in the past and expect to do so in the future .

The AFL-CIO is quite aware that many amendments have been proposed to you and to the members of the subcommittee by the National Governors' Association, the National Association of Counties, the American Health Planning Association, the American Hospital Association, by the Group Health Association of America and by the Consumer Coalition for Health and others.

The Consumer Coalition developed out of the Consumer Conference on Comprehensive Health Planning which the AFL-CIO cosponsored along with a number of other consumer organizations last June and at which you, Mr. Chairman, were the feature speaker. Mr. Chairman, I believe that in future years you will look back and have reason to believe that you played a significant role in achieving effective consumer participation in the health planning process. Speaking for the AFL-CIO, we have been urging our state and local organizations to seek representation on Health Systems Agencies (HSAs) and on Statewide Health coordinating Councils (SHCCs). The AFL-CIO is committed to making health planning work.

The health planning law was passed three years ago. The last three years have witnessed the organization of more than two hundred HSAs, employing their staffs and complying with regulations that have been promulgated but unfortunately, rather slowly. In fact, not all of the regulations have been promulgated as of this date.

During these last three years only a handful of HSAs have been fully designated. That is, only a few HSAs have developed their long range planning goals (HSPs) and Annual Implementation Plans (AIPs). Within the next year it is expected that most HSAs will have completed their long and short term plans.

In spite of the fact that the organizational phase has not yet been completed and not all of the regulations have been issued, some proposed amendments have been proposed which would alter the basic structure of the planning agencies. The AFL-CIO believes this new legislation should be given a chance to work without a restructuring of the system that is now in place. Specifically, we oppose the amendments that have been proposed by the Governors and by the Counties. This is not to say that non-structural improvements should not be made. In fact, both labor and management are in agreement that some changes should be made.

Last year, the Labor-Management Group, which AFL-CIO President Meany and Reginald Jones of General Electric co-chair, identified twelve areas of mutual concern in the health care field. The Labor-Management Group directed labor and management staff to develop specific recommendations on each of the twelve issues.

On January 19, 1978, the Labor-Management Group adopted the first three papers recommending cooperation in achieving mutual goals in three areas. These are:

* Health Planning
* Health Maintenance Organizations (HMOs).
* Prospective Reimbursement

We attach a list of members of the Labor-Management Group as well as the three implementation papers as an appendix A.

Labor and management representatives were in complete agreement that both labor and management should be represented on all health planning bodies: local, state and national. Through the process of collective bargaining, labor and management are major purchasers of care in behalf of millions of consumers. The law should, therefore, specifically require a representative of organized labor and a representative of management be on each HSA, each SHCC and the National Council on Health Planning and Development. While labor has a representative on the National Council, management does not. We think management should be represented. In fact, we think a representative from organized labor and from management should be mandated by law.

The Labor-Management Group also expressed concern about the fact that in some cases, labor or management or both have been denied representation on HSA governing bodies and on SHCCs as consumer representatives simply because the individual supported by labor or management to serve also served on a Blue Cross-Blue Shield, hospital or prepaid group practice plan board. This problem would possible be best resolved by requiring representation of labor and management as major purchasers of care on all HSAs, SHCCs and the National Council as part of the consumer majority.

Since the principal purpose of medical services is to improve the health and well being of patients, it is axiomatic that consumers should have the predominate voice in health planning. While current law requires a majority but no more than 60 percent of HSA governing bodies be consumers, this usually means about a 51 or 52 percent majority. This does not lead, however, to a predominance of consumer influence.

Consumers have several handicaps in achieving effective representation. Planning decisions are likely to affect the interests and income of providers very directly but the effect is indirect on consumers. Consumers' attendance at meetings, therefore, often falls far short of translating into a majority actually present and voting. Another handicap is that hospital administrators and other institutional providers consider attendance at agency board meetings as part of their job. Institutional providers can study agency plans on the job, but for consumers, preparation must be made at home and in their spare time. Hospital administrators can tap an extensive staff of administrators, lawyers, accountants, statisticians and consultants. In fact, a large hospital in New York spent several hundred thousand dollars to contract with a consulting firm to plan and justify an expansion. About a week before the planning agency was scheduled to consider this project, the consumer members were sent copies of a massive several volume study.

Consumer members do not have the time to contend with this massive deluge of paper and are, therefore, severely handicapped with respect to the influence they can bring to bear on the planning process.

It would indeed be a tragedy if the HSAs and SHCCs become dominated by providers as they have, in fact, dominated the former planning agencies established prior to the present law. If this happens, planning would likely become a force to maintain the status quo rather than a force for change.

To achieve a more equitable balance between consumer and provider interests, the percentage of consumers on HSAs and SHCCs should therefore be raised to a minimum of 60 percent (the current maximum). Even this percentage probably cannot achieve equity between consumers and providers unless some other steps are taken as well. That is why the Labor-Management Group in its statement indicated the need for development of staff capabilities for consumers who lack such resources.

We, therefore, propose that the planning law should provide technical assistance to consumer participants at all levels of the planning process. Each HSA should have at least one consumer advisor who should be completely separate from the rest of the staff of the HSA and be responsible to the consumer members.

There should also be a requirement that all consumer members of HSA governing bodies should be provided with an orientation training program of not less than 10 hours.

One of the major deficiencies of the planning act is historical. The older Hill-Burton Planning Law only considered need as a reason for building a hospital, and the Hill-Burton planning guidelines were very liberal in defining need. One of the guidelines for HSAs in the health planning law is that of "restraining increases in the cost of providing them (residents) health services."

Planners seem to think any capital expenditure is wasteful. The fact is that many capital expenditures are cost effective. The Labor-Management Group has, therefore, recommended "that cost-effectiveness be specifically stipulated as a planning criterion by local health planning agencies." Unfortunately, lack of consideration of cost effectiveness permeates the

planning agencies from the HSAs up to the Bureau of Health Planning in HEW. The result has been that planning agencies have stopped the development of prepaid group practice plans, have placed barriers in the way of their expansion, have attempted to restrict the granting of a certificate of need for prepaid group practice to poverty areas (the poor cannot afford comprehensive medical care) and have prevented prepaid group practice plans from building hospitals.

We attach eight case histories of instances where HSAs have blocked or restrained the development of a prepaid group practice plan. These case histories are attached as appendix B.

Prepaid group practice plans and especially those plans that own their own hospital are the most cost effective delivery system we have in the United States. The Department of Health, Education and Welfare estimates that prepaid group practice plans are from 10 to 40 percent less costly than traditional insurance.

The cost effectiveness of an HMO is proportionate to the extent it controls and operates the facilities it utilizes. Thus a study conducted by the University of California found that a large hospital-based program saved 35 percent while a smaller non-hospital based plan saved 15 percent compared with the average cost of Blue Cross-Blue Shield or commercial insurance.

Moreover, a Federal Trade Commission study showed this competition impacted in the fee-for-service system by lowering community-wide hospital utilization rates. Another study done for HEW shows the total cost of hospital care to a community is less even when prepaid group practice plans are allowed to build hospital beds in a community with surplus beds.

Congress has adopted two strategies for containing costs. The Planning Act adopted a strategy of regulation. The Health Maintenance Act adopted a strategy of competition. There is no reason why Congress cannot marry the two strategies. They need not conflict, but to avoid this the Planning Act needs to be amended.

We suggest several alternatives to this committee for your consideration.

1. The most desirable solution would be for planning agencies to regulate the fee-for-service sector and for the HMO Division of HEW to regulate prepaid group practice plans. This would enhance competition and lodge regulatory authority in the agencies that understood these two programs. As it is now, prepaid group practice plans are regulated twice -- by the HMO Act and by the Planning Act. Fee-for-service ambulatory care is not regulated at all, unless of course, the amendments you propose, Mr. Chairman, are adopted and even then fee-for-service would only be subject to one set of regulations.

2. Another possibility would be to retain HMOs under the Planning Act, but exempt them from Certificate of Need. In such case the planning agencies should be limited to review and comment on new HMOs with the final determination up to the Secretary.

3. The Labor-Management Group has proposed the following with respect to this problem: Federal law should require that HMOs have proper appeal procedures to the Department of HEW if they believe they have been treated unfairly; and sanctions should be imposed against HSAs which are proved to treat HMOs less favorably. This would ensure that HSAs treat HMOs as favorably as the fee-for-service sector in order to allow HMOs to compete effectively and provide necessary services and facilities for their enrolled members.

We now wish to make some comments on some specific provisions of H.R. 10460.

Section 101 of the bill provides for only a one year extension of the program. This is insufficient. The AFL-CIO recommends a three year extension to give the program an opportunity to work. Only seven HSAs have been fully designated. It will probably be another year before all HSAs achieve that status and be in a position to implement these long and short term plans.

Section 202 should include cost effectiveness as a way in which to contain the rising cost of health care delivery. In fact, amendments to the planning law should include the criterion of cost effectiveness wherever the word "need" is used.

Section 208 would remove the prohibition against an HSA accepting funds from health care insurers and using those funds as a basis for Federal matching.

We strenuously oppose this provision. This is an invitation to Blue Cross-Blue Shield and commercial insurance to dominate the health planning process. When have these financial interests supported the interests of the consumers of health care? In Medicare? National Health Insurance? They are part of the problem, not part of the solution.

Section 209(a) of the bill includes the requirement that HSA governing bodies include labor organizations. Naturally, we strongly favor this provision, but we also endorse the recommendations of the Labor-Management Group that both labor and management should be represented on HSAs as major purchasers of care through the collective bargaining process. We subscribe to the concept that Blue Cross-Blue Shield and commercial insurance companies should be represented on HSA governing bodies as indirect prividers of care.

Section 209(a)(3) should add nonprofessional employees to the list of prividers listed in Sec. 1512(b)(3)(c)(ii) of the present law.

Section 209(b)(2) assures representation of general purpose local governments on HSA governing bodies. For the most part, they are already so represented. The issue is what percent of the HSA governing body should public representatives. Since the AFL-CIO recommends 60 percent consumer representation, the proportion of representatives on such governing bodies who are there as direct and indirect providers and the proportion who are public representatives per se should be limited to 40 percent overall.

Sec. 211(a) provides that when the HSA is a public regional planning body or a unit of general local government, the public board shall have responsibility for the establishment of personnel rules and practices for the staff of the agency and for the agency's budget unless such functions are specifically delegated to the governing body for health planning. This would effectively give control of such agencies to local government. This is, in our opinion, a substantive change in the structure created by the planning law and would involve substantial delay in implementing the law. We, therefore, oppose this amendment.

Section 213(a) of the bill requires that each HSA have an identifiable program of providing assistance to the members of its governing body. The AFL-CIO supports this provision except that such technical assistance, support, training and continuing education should be primarily directed to the consumer representatives on such governing bodies.

Section 213(b) allowing advances to board members for the reasonable costs incurred in attending governing body meetings should be changed to allow reimbursement of actual expenses to board members for the reasonable costs of attending such meetings. This is particularly important for HSAs that cover a large rural area.

Section 216(c) requires the State Health Planning and Development Agency to determine the health needs of the state which are statewide and requires the HSAs to develop their plans in a way which is responsive to those statewide health needs. This is top-down planning rather than bottom-up planning. This violates the intent of present law. It is, therefore, a major structural change which the AFL-CIO opposes at the present time.

Section 218(a) requires that a certificate of need provide for the review and determination of need for major medical equipment, health care facilities, institutional health services, home health services and capital expenditures. Prepaid group practice plans should be exempt from this provision. Also, cost effectiveness should be included as well as need in the review process. Cost effectiveness should be added as a criteria in Section 1527(a) (1), (2), (3), (4), (5) and (6) of present law. Other relevant sections of the law should be conformed.

Section 219(b) requires each state within four years to have in effect a state program to close unneeded institutional health services. Such state programs should be required not only to provide relief for financial obligations but also to provide severance pay and a program for reemployment of employees affected by facility closures. This is a recommendation of the Labor-Management Group.

Section 223(b) requires the Governor to select the chairman from the membership of the SHCC. Present law provides for election of the Chairman by the members of the SHCC. The AFL-CIO opposes this change as a major structural change in the law.

Section 301 provides loans and loan guarantees for modernizaiton and construction of medical facilities with emphasis on new outpatient facilities in areas of rapid population growth and underserved areas. This section also authorizes grants to public hospitals. We urge these construction grants and loans also be made to qualified prepaid group practices plans.

Mr. Chairman, the sections of H.R. 10460 to which we did not specifically refer have our support or neutrality. We hope that Congress will quickly act upon these amendments along with our suggested improvements. We especially urge the law be renewed for three years.

Appendix A

Labor-Management Group Recommendations On:

1. Health Planning Needs
2. Health Maintenance Organizations (HMOs)
3. Prospective Reimbursement

Summary of Health Planning Needs

Issue

To avoid duplication of facilities and equipment, legislation has been enacted to encourage community planning for facilities, sharing of high cost equipment, etc. This legislation needs strengthening to make local planning more workable.

Background

- Scattered health planning was in effect for a number of years prior to 1974, but there is little evidence that it effectively controlled health care related capital expenditures.
- The National Health Planning and Resources Development Act of 1974 established a new, nation-wide planning structure, providing for the establishment of Health Systems Agencies (HSA's) and health planning processes, the requirement for periodic review of all institutional health services and certificate-of-need legislation in all states by 1980.
- Approximately 200 HSA's have been created. While still developing, the HSA System shows promise in controlling expenditures.

Recommended Actions

1. The Labor-Management Group recommends that business and unions work at the state and local levels to enhance the effectiveness of the planning mechanism by:
   - Seeking membership on State Health Coordinating Councils (SHCC's), local HSA Boards and hospital boards.
   - Cooperating in areas where large employers and/or employee groups can influence local planning as consumers.
2. Labor and Management should participate in the improvement of the health planning system by:
   - Recommending to the Administration that both Labor and Management have representation on the 15-member National Council on Health Planning and Development.
   - Recommending that cost-effectiveness specifically stipulated as a planning criterion by local health planning agencies.
   - Supporting the strengthening of state health plans and certificate-of-need (CON) programs, including:
     - Extension of CON to government health care facilities.
     - Tighter enforcement of CON decision.
     - Withholding Medicare/Medicaid and other third-party reimbursements from non-approved facilities.
3. Work to improve the Federal Health Planning Law:
   - Provide states with authority to decertify health care facilities where warranted.
   - Extend HSA authority to include review of non-hospital capital expenditures, e.g., physicians, other ambulatory care.
   - Extend HSA review process to government medical facilities.
   - Encourage participation in HSA's of informed consumers; provide them with resources to aid in technical evaluation.
   - Improve the definition of providers to remove the limitations which prevents an indirect provider (i.e. an employer or union on a hospital board) from acting as a consumer.

HEALTH PLANNING

Background

- Scattered health planning had been in effect for a number of years prior to 1974, but there exists little evidence that planning was able to effectively control health care related capital expenditures -- either by voluntary or regulatory approaches.

- With the passage of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), a new, nation-wide planning structure was established. Some of the main provisions of the law are:

  - It established across-the-nation Health Systems Agencies (HSAs) and health planning processes, revising and replacing the existing planning agency approach.

  - It gave the new planning agencies greater authority over area-wide planning and federally-funded programs than their predecessors.

  - It required the new agencies to carry out a periodic review and evaluation of all institutional health services.

  - It required certificate-of-need legislation in all states by 1980, with any hospital expenditure of $150,000 or more subject to HSA review.

  - It required health care providers to conform to long and short range health plans developed by local and state health planning agencies.

  - It required HSAs to have consumers as a majority on their boards who are independent of any health care provider.

- The nation-wide planning system established by the Act is still developing. At present, approximately 200 HSAs have been created. The HSA system shows promise in controlling health care expenditures.

Recommended Actions

1. Increased Labor-Management Participation in Local Health Planning

   Controlling the capital expenditures available to the health system through the planning mechanism is one method of changing the current incentives toward overdevelopment of facilities, which are a function of the non-free market structure of the health care delivery system. The HSA system provides for the necessary "localization" of the regulatory process.

The Labor-Management Group recommends that business and unions work at the state and local levels to enhance the effectiveness of the planning mechanism in several ways:

- By seeking membership in or appointment to State Health Coordinating Councils (SHCCs) and local HSA Boards and/or Executive Committees and hospital boards in areas where labor and management have not heretofore been represented.

- Once represented on a SHCC, HSA or hospital board by remaining actively involved, aggressive and well-informed in order to insure that capital expenditures are controlled.

- By cooperating in areas where large employers and/or employee groups can combine their influence as consumers of health care to aid planning agencies and hospitals in their efforts to control health care costs.

- By supporting or establishing training programs for labor, management and other representatives who serve on hospital and planning boards and their committees.

2. Improvement of the Health Planning System

The health planning system mandated by law is currently being developed through the continued formation of planning agencies and implementation of local and state programs. This development will be an ongoing effort over the next several years.

Labor and management can participate in the development and improvement of the health planning system by:

- Recommending to President Carter and Secretary Califano, that both labor and management have representation on the recently established 15-member National Council on Health Planning and Development, whose purpose is to consult with the Secretary of HEW on: 1) the development of national health planning guidelines; and 2) the implications of new medical technology for organizing, delivering and equitably distributing health care services. Currently, labor is represented on the Council but management is not.

- Recommending that cost-effectiveness be specifically stipulated as a planning criterion by local health planning agencies. For example, it appears that some HMO's which may prove to be cost effective, are not obtaining required certificates-of-need due to lack of consideration of cost-effectiveness in the decision to grant CON.

Supporting development of state health plans and certificate-of-need (CON) programs. Although there are CON laws in a number of states (all states must have them by 1980), they have been less effective than intended due to a number of legislative inadequacies at the state level.

- Currently, CON is only required for hospital capital expenditures. In order to achieve uniform control over all health provider sectors, CON should be required for all capital expenditures over state-determined base levels of more than $100,000 and applied to non-hospital capital projects such as ambulatory care centers, ambulatory surgical centers, clinics of any type, and expensive medical equipment in physician's offices.

- Currently, CON is not required for Federal government health care facilities, permitting expansion which may be inconsistent with other health planning objectives for a given area. Therefore, CON should be required for both Federal and non-Federal facilities.

- Currently, hospitals and additional beds are being added in communities in spite of disapproval by a state CON agency. CON procedures should be strengthened and CON decisions rigidly enforced to prevent duplication and overbedding. Accordingly, CON approval should be denied for the addition of any type of institutional bed facility in an overbedded area unless the new facility (e.g., an HMO hospital) will be more cost effective than the existing one, which it will replace. Therefore, underutilized existing facilities would be used for as long as such area remains overbedded unless replaced by more cost-effective facilities.

- Currently, state laws do not require recertification (ongoing review and approval) of projects which received CON, often resulting in underutilization of facilities in an area as population, demographics, etc. change over time. Periodic recertification should be required to assure that the facilities which received CON are still necessary.

- Currently, CON legislation has not been enacted in many states, thereby permitting unnecessary facilities to be built and third-party payor reimbursement provided to support the operation of such facilities. Medicare and Medicaid reimbursement may be prohibited for unapproved facilities under Section 1122 of the

Social Security Amendment. However, some states do not have an agreement for Section 1122 reviews. Therefore, if HSA approval is denied, Medicare and Medicaid reimbursement to unapproved facilities should be prohibited in all states as provided under Section 1122.

In addition, if HSA approval is denied, labor and management, through collective bargaining and otherwise, should be urged to require third-party payors (insurance carriers) to cooperate to develop agreements which will deny reimbursement to such unapproved facilities. If such action proves to be uneven in application or ineffective in limiting the establishment of unapproved facilities, labor and management, through collective bargaining and otherwise, should urge consideration of statutory action to limit third-party payor reimbursement to such unapproved facilities, in whole or in part, as applicable.

3. Amendments of the Federal Planning Law

The Federal Planning law, while providing the framework to control capital expenditures in the health care area, does have a number of deficiencies.

Labor and management should work for amendment of the law at the Federal level which will correct such deficiencies.

- Since consumers on HSAs are often not as effective or well informed as health care providers, the participation of consumers (in terms of the law), who are major payors (i.e., companies and unions) which have staff resources available should be stimulated and the development of staff capabilities for consumers who lack such resources should be encouraged.

- A consumer who is on the board of an HMO or a hospital is classified as an indirect provider according to Federal definition. Due to the influence of health care providers (e.g., physicians), this type of indirect provider (really an informed consumer) may be denied a place on an HSA. Therefore, the definition of providers, indirect providers, and consumers should be reexamined to ensure better equity of representation on HSAs.

- In order to make recertification of CON laws effective, states should have the authority to decertify health care facilities where warranted, and the states should be encouraged to develop a facilities closure financial plan which should include adequate provision for severance pay and/or reemployment of employes affected by facilities closures.

- Since HSA approval is not currently necessary for non-hospital equipment and facilities, HSA authority should be extended to include review of all major equipment purchases, including those by physicians or other ambulatory care providers.

- Although development of Health Maintenance Organizations (HMOs) is listed as a priority in the law, there has been evidence that HMOs are not always equitably evaluated by HSAs, which sometimes tend to focus on short-range cost effectiveness where HMOs are at a disadvantage. Over the longer term, however, HMO cost performance would reflect more favorably. Therefore, Federal law should require that: 1) HMOs have proper appeal procedures to the Department of HEW if they believe they have been treated unfairly; and 2) sanctions should be imposed against HSAs which are proved to treat HMOs less favorably. This would ensure that HSAs treat HMOs as favorably as the fee-for-service sector in order to allow HMOs to compete effectively and provide necessary services and facilities for their enrolled members.

- Since government medical facilities do not come under the HSA review process, they should be brought under such process so that government medical facility expansion is not incompatible with local health planning. This should be undertaken with the necessary understanding that a portion of government medical facilities' patient load is national rather than local in origin.

Summary of Health Maintenance Organizations (HMO's)

Issue

Efforts must be made to promote the development and thorough evaluation of HMO's, and to correct legislative and health planning defects that limit their flexibility and growth.

Background

- HMO's are health organizations that provide comprehensive health care on a pre-paid per capita basis. This payment method rewards HMO's for preventing illness, utilizing less costly methods of treatment and minimizing hospital admissions and lengths of stay.
- Initial Federal HMO legislation was too stringent to encourage growth of HMO's. Amendments in 1976 helped ease qualification, but some barriers remain.
  - Mandated benefits are too broad.
  - Qualification regulations remain extremely complicated.

Recommended Actions

1. Work to remove barriers to HMO development:
   - Reduce the mandated scope and duration of HMO benefits to allow for tailoring to needs of employee groups.
   - Simplify qualification requirements.
   - Amendments to Medicare to permit payments on basis of predetermined rate comparable to private sector payments.
   - Providing a minimum enrollment period under Medicaid to prevent expenses exceeding revenues.
2. HMO Act amendments should be supported which would:
   - Make capital loans and capital loan guarantees to HMO's subject to favorable CON review and Federal qualification.
   - Provide for technical assistance for HMO development and funds for the training and continuing education of HMO personnel.
3. Labor and Management should cooperate on a plant and local community level to promote the development of new HMO's and the expansion of existing HMO's under the provisions of the HMO Act.
4. Support increased monitoring and evaluation of the cost effectiveness of HMO's.
5. Encourage improved evaluation of HMO's by local planning agencies which tend to treat HMO's less favorably than the fee-for-service institutions.

DEVELOPMENT OF HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Background

- HMOs are health organizations structured differently from fee-for-service medical practices. They provide comprehensive health care on a pre-paid, per capita basis. This method of payment rewards HMOs for preventing illness, utilizing less costly methods of treatment and minimizing hospital admissions and lengths of stay.

- Initial Federal HMO legislation was too stringent to encourage growth of this type of organization. Amendments were made in 1976 to qualify HMOs more easily under the Act, but there remain some barriers to the formation of additional HMOs.

  - A major existing barrier is that the mandated benefits are too broad, making it difficult for HMOs to compete.

  - Qualification regulations remain extremely complicated and difficult to conform with.

- Health Maintenance Organizations have the potential to impact health care costs favorably. Available data show that hospital days per 1,000 enrollees are less than comparable figures for the non-HMO population in the same service areas.

- According to a recently released Federal Trade Commission study, generally HMOs effect reductions of overall health care costs in their service areas

Recommended Actions

1. Work to Remove Barriers to HMO Development

Labor and management should work to have legislative, regulatory, enrollment and other barriers to the development of HMOs which still exist removed.

- Labor and management should work together to seek amendments to the Medicare and Medicaid statutes, and in the HMO law itself.

  - Currently, Medicare payments are only permitted on a retrospective basis; Medicare should be authorized to pay qualified HMOs on the basis of a predetermined fixed capitation rate just as the private sector does.

  - Currently, there is no minimum enrollment period for Medicaid participants in HMOs' as a result, HMOs often are reluctant to accept Medicaid patients for short time periods in which treatment expense may exceed revenues. Therefore, where demonstrated cost savings potential exists, a minimum enrollment period for Medicaid enrollees in HMOs should be required.

Currently, HMOs must provide a level of benefits which are well in excess of many existing benefit program levels; the cost of providing this level of benefits makes HMOs less flexible in competing with traditional insurance plans. Therefore, the mandated scope and duration of HMO benefits should be reduced to allow tailoring of benefits to the needs and resources of employe groups.

- The Federal government should attempt to simplify qualification requirements for HMOs.

2. Support Increased Evaluation of HMOs

Labor and management support continued data collection in order to monitor and evaluate the cost effectiveness of HMOs. Data compiled to date indicate cost savings can be achieved by use of HMOs. However, a broader data base would enable both: 1) a more comprehensive evaluation; and 2) analysis of specific HMO organizational structures to point out the most cost-efficient methods of operation.

3. Encourage Improved Evaluation of HMOs by Local Planning Agencies

Although development of HMOs is listed as priority in the law, there has been evidence that HMOs are not always equitably evaluated by HSAs, which sometimes tend to focus on short-range cost effectiveness where HMOs are at a disadvantage. Over the longer term, however, HMO cost performance would result in lower cost than under conventional fee-for-service arrangements. Therefore, the planning law, regulations and planning agencies should treat HMOs as favorably as the fee-for-service sector under certificate-of-need (CON) provisions in order to allow HMOs to compete effectively and provide necessary services and facilities for their enrolled members. HSAs which are proven to violate this principle should be subject to sanctions.

4. Support Programs to Provide Financial and Technical Assistance to HMOs

Currently, HMO development is hindered by a lack of capital funds and qualified operating personnel. HMO Act Amendments should be supported which would:

- Make capital loans and capital loan guarantees available to HMOs, subject to favorable CON review and Federal qualification certification, for the construction of facilities which demonstrate significant cost reduction potential. However, the Labor-Management Group favors the use of existing facilities, whenever more cost-effective than new construction, so that duplication of facilities should be avoided. Under present law, grants are available for feasibility surveys, planning and initial development, and loans are only available to cover operating costs.

- Provide for technical assistance for HMO development and funds for the training and continuing education of medical directors, marketing directors and administrators of HMOs, since HMO personnel are often not adequately trained and could use such assistance and education.

5. Encourage Development and Utilization of HMOs

Existing dual choice provisions state that an employer, contacted by a federally-qualified HMO serving an area in which at least 25 employes of that employer reside, would be required to offer to its employes a choice between a federally-qualified HMO in the area and the traditional employer health plan. Under such provisions of the HMO Act, labor and management should cooperate on a plant and local community level to promote the development of new HMOs and the expansion of existing HMOs. This effort could include sponsorship of educational programs to communicate the HMO concept to employes, the development of educational literature and general health education. Such labor-management efforts, particularly if organized on a community level, could also result in more effective negotiations with hospitals, fee-for-service physicians and insurers.

Summary of Prospective Reimbursement

Issue

The prevalent method of reimbursing hospitals (on a cost plus basis) leads to escalating costs. In place of that practice, the Labor-Management Group prefers that hospitals be reimbursed on the basis of budgets or fixed schedule of reimbursement established in advance.

Background

- Economists and others partially attribute the high cost of medical care to the traditional system of reimbursing hospitals on a retrospective (after the fact) basis.
- The method of basing reimbursement upon prospectively established budgets or rates has received increasing support as a means to control costs.

Recommended Actions

1. SUPPORT COMMON PRINCIPLES FOR PROSPECTIVE REIMBURSEMENT
   - A uniform payment mechanism to be employed by all third-party payors which takes account of all sources of revenue and total hospital expenditures.
   - Setting prospective reimbursement levels for individual hospitals based on approved payment rate, utilization of hospital services, case mix of patients and intensity of services.
   - Provision for incentives for hospitals to adhere to prospectively set budgets and to operate efficiently.
2. ENCOURAGE THE DEVELOPMENT AND EXPANSION OF PROSPECTIVE REIMBURSEMENT PROGRAMS
   - Labor and Management should actively support prospective reimbursement programs directly and indirectly by encouraging its adoption by carriers, government, Blue Cross, Health Insurance Association and other third-party payors.
   - Support extension of the concept to all government hospital care payment programs.
   - Support Federal Government efforts to evaluate the effectiveness of the concept.

PROSPECTIVE REIMBURSEMENT

Background

* Economists and other observers of the health system have noted that one of the forces which contributes to the high cost of medical care is the traditional system of reimbursing hospitals on a retrospective (after the fact) basis. Under this system, hospitals have determined their own reimbursement levels with little regard for cost, and without approval by or negotiation with third-party payors.

* Since appropriate redesign of the reimbursement system could be a powerful incentive for cost containment, the method of basing reimbursement upon prospectively established budgets or rates has received increasing support.

* Currently, state regulatory efforts, Federal research and private sector experiments by insurance carriers are stimulating and evaluating prospective reimbursement programs. While there are still many unknowns, experience to date, both in the United States and abroad, has indicated some principles which are important aspects of a successful program.

Recommended Actions

1. Support Common Principles for Prospective Reimbursement

Based upon experience to date, the Labor-Management Group believes that prospective reimbursement programs, to the maximum extent feasible, should embody the following principles if they are to be effective:

* A uniform payment mechanism should be employed by all third-party payors (government and insurance carriers) which takes account of all sources of revenue (including those of private payors) and total hospital based expenditures. Exempting certain expenditures from a reimbursement formula (e.g., radiology services) can allow hospitals to pass excessive expenses along through charges made for such services.

* Setting prospective reimbursement levels for individual hospitals must address these varying functions (e.g., teaching hospitals) and size and, in particular, these four key factors:

  a. Payment rate (the approved charges for specified hospital services);
  b. Changes, if any, in utilization of hospital services;
  c. Changes in case mix of patients;
  d. Changes in intensity of services (i.e., quantity and complexity of care).

- The reason this is necessary is that the above specified changes may abnormally increase or decrease a hospital's expenses in relation to budget projections based on historical data and the estimated payment rate. Therefore, all of these factors need to be considered.

- Incentives for hospitals to adhere to prospectively set budgets and to operate efficiently should be included (e.g., giving a hospital a "bonus" if it comes in under budget); and

- Allocation of operational resources within hospitals should continue to be determined by the hospital administration, rather than by third-party payors or other external groups.

2. Encourage the Development and Expansion of Prospective Reimbursement Program

- Labor and management, as well as insurance carriers, government, the Blue Cross Association, the Health Insurance Association of America and other third-party payors, should actively promote the development and expansion of prospective reimbursement programs. Special emphasis should be placed on prospective reimbursement systems under employe benefit plans.

- The Labor-Management Group supports the extension of prospective reimbursement to all government hospital care payment programs, provided no additional cost is passed along to the private sector.

- Labor and management members who serve on hospital boards should encourage hospitals to cooperate in adopting prospective reimbursement systems and establishing sound business practices of operation.

- The Labor-Management Group supports efforts of the Federal government to evaluate current prospective reimbursement programs.

Appendix B

1. Family Health Plan, Greendale, Wisconsin
2. Group Health of El Paso, Inc., El Paso, Texas
3. Health Maintenance Organization of Baton Rouge, Inc.
   Baton Rouge, Louisiana
4. Community Health Care, Inc., Lincoln, Nebraska
5. Rutgers Community Health Plan, New Brunswick, New Jersey
6. Group Health Association, Inc., Washington, D. C.
7. Health Care Plan, Inc., Buffalo, New York
8. Valley Health Plan, Amherst, Massachusetts
9. Other Plans Blocked by HSAs

Family Health Plan, Inc.
5413 S. 76th Street
Greendale, Wisconsin 53129

BACKGROUND: Family Health Plan is preoperational, proceding under the HMO grant program. The HMO is entering the initial development phase, requiring review by the Southeastern Wisconsin Health Systems Agency. The review process was complicated by recent passage of certificate-of-need legislation in the State of Wisconsin.

REVIEW PROCESS: Due to the certificate-of-need legislation, FHP was subjected to two separate reviews - one for the program and one for the facility. SEWHSA staff decided that the review process would be simplified by using the same review committee to do both reviews.

Program review resulted in few problems. The necessary application was submitted in July to the HSA. A minor problem developed in ascertaining whether the new legislation applied to this project. SEWHSA was neither sure of the law's applicability nor were they sure of the appropriate forms that had to be submitted. It is our opinion that this is not their fault since the state passage of the law was occurring concurrently and final regulations were somewhat ambiguous.

The program review took place on July 28, 1977, with only a few minor objections by committee members. The staff recommendation was very favorable. Approval of the program specifically did not include the facility which was left open until a subsequent review would take place. The executive board confirmed the program approval on August 4, 1977.

Facility review under 1122 posed the most serious problems. SEWHSA staff review and recommendation on the application again was very favorable. The review took place September 22. During the discussion, a number of negative points were brought up and refuted by FHP staff present at the review. The review committee finally recommended approval by a margin of one vote, that being cast by the committee chairman.

The executive committee of the SEWHSA subsequently turned down the application on October 6, citing 5 reasons for the rejection. FHP staff felt the rationale was unjustified. Two options remained, - either seek an appeal or attempt to get the state to reverse the committee's decision. The FHP Board took the former route. FHP staff submitted documentation to refute each of the five reasons for disapproval, and at a subsequent review on November 3, obtained approval for the facility.

MAJOR DIFFICULTIES: From the standpoint of an HMO, a number of difficulties with the review process were perceived. These are:

1. Inability of review committee members to reasonably evaluate a program like an HMO. It is the contention of FHP staff members present that the committee members do not really understand what an HMO is. Several committee members continued to perceive the HMO as a subsidized plan which is to serve the low-income population. Location of facility was a major issue. Committee members wished the HMO to locate very close to the low-income population to increase their access to care. However, this would have had a significantly negative effect in attempting to reach the primary market the HMO intends serving. Committee members would evaluate "need" for the project only on the basis of providing care to an under-served population.

2. Protection of personal interests by review committee members. Since the review committee has ample representation from providers of health care, it appears that some view HMO's as a potential threat. Because of this fact, and HMO will certainly face a hard core of committee members who will be trying to protect the "status quo". The most outspoken plan critics were providers of health care, especially physicians, some of whom were not even close to the proposed service area. It goes without saying that new programs such as this will always have to struggle against established participants in the health care field, due to the committee structure.

3. Refusal of committee members to deal with relevant issues. Much of this can be attributed to the prior two points. FHP staff successfully refuted the five major objections to approval. In the subsequent re-review, almost no mention was made of the issues; instead, other issues, mainly those of personal opinion, were brought out. Since the reviewee is unable to speak at an executive board review, many issues that could have been refuted went unanswered and swerved other committee members.

4. Lack of clear, concise standards by which an HMO can be evaluated. No clear criteria exist to guide HSA committee members in their decision. For example, it is difficult to evaluate need for a project, when no standards of need have yet been developed for an HMO review. Since there are no applicable guides, committee members use their own criteria.

SUMMARY: The whole review process was a strenous undertaking for FHP staff. The process took nearly five months from beginning to end and involved substantial time and effort. The process created a great deal of uncertainty and set the HMO's timetable back 60 days. While we could appreciate the cooperation of SEWHSA staff, the review process leaves a lot to be desired. After all, the primary objective of an HMO is cost-control, which is, after all, one of the major goals of the HSA.

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Barry C. Strittmatter, President

Group Health of El Paso (GHEP) submitted an Initial Development Application to the local HSA. The application had already received approval by the Regional Office of HEW. On July 13, 1976, the application was presented to the Project Review Committee. This Committee submitted 'Negative Comments' to the HSA on July 15, 1976, at which point the HSA voted to table the project for 30 days in order to study the problem. On August 18, 1976, the HSA took an informal poll which showed nine (9) members against, one (1) for, and twelve (12) abstentions. When this information was made available to the West Texas Council of Governments, the Council directed the HSA to submit a definite decision. The HSA then voted "no comment". The Council subsequently voted unanimously to approve the project.

The factors which contributed to the indecisiveness and negative comments on the part of the HSA can be categorized as follows·

(a) Complexity of HMOs preclude an effective evaluation by planning agencies without definite guidelines.

All facets of HMOs are not understood by HSA members. Often comments are based on factors which do not account for

HMO legal requirements, and opinions are formulated in reaction to HMO philosophy rather than the specific needs of the project under evaluation.

This experience is exemplified by the Review Committee's recommendation of 'Negative Comments', which were based on the following reasons:

1. The program was too restrictive because it did not include all physicians and hospitals in El Paso.
2. The plan had asked for too much money in the budget. [The Committee had not reviewed the budget, but felt that $528,000 was too much money, just to develop an HMO]
3. Since they had already been funded for two years and had not become qualified, it should not be continued for an additional year.

The President of GHEP attempted to overcome the apparent lack of basic knowledge of HMO statutory requirements, structure, and funding provisions by explaining those aspects of HMO law to the HSA members. As evidence by the HSA's continuing indecisiveness, an ad hoc education of HSA members does not meet the problem. Firm criteria must be supplied if HMO's are to be adequately evaluated by planning agencies.

(b) Conflict of Interest -- Provider hostility of HMOs.

The Chairman of the Project Review Committee and the HSA is a member of the Trans-Pecos Medical Foundation; a separate entity which has applied for a feasibility grant under P. L. 93-222. Five members of the Board share a common office complex area, as medical doctors on the board are represented outside of the Trans-Pecos Foundation for Medical Care.

Although the members with direct conflict of interest ultimately abstained from voting, the influence sustained throughout the discussion was unquestionably substantial. The problem is particularly acute in this case in that the chairman of the HSA and the Project Review Committee, while conceding to a conflict of interest, proceeded to lead the discussion at all times.

Health Maintenance Organization of Baton Rouge, Inc.
5790 Florida Boulevard, Suite 206
P. O. Box 64967
Baton Rouge, Louisiana 70806
Director: Joseph H. Carabello

Health Maintenance Organization of Baton Rouge, Inc. (HMOBR) initially submitted a planning grant application for review by the local 314(b) agency under the HMO Act of 1973. On July 9, 1975, HMOBR forwarded a second application for a planning grant to the local health planning council for its review. In both instances, the local agency recommended disapproval. HEW overrode both recommendations, however, finding that an HMO was feasible and that the planning should continue.

Thereafter, HMOBR submitted an application for its Initial Development Phase to the newly formed HSA. Prior to the reorganization, the application had been reviewed by the former 314(b) agency, which had forwarded its recommendation for approval to the board of the HSA, as well as to the State Health Planning Council. On the 58th day of the review cycle, HMOBR received a certificate of need from the State Health Planning Council. On the 62nd day of the review cycle, the HSA board voted to recommend disapproval. The action was essentially initiated, however, by the lapse of the allowable review period and by the issuance of a certificate of need.

The process of evaluation reflects the many inadequacies demonstrated by HSA's in dealing with HMOs. Emphasis on criteria outside of the agency's scope of review and the general refusal to approve the project based on a dislike of the HMO philosophy are evident in the minutes of the HSA's meetings. Examples of this are documented below.

(I) Requirements of consumer representation were not adhered to during the review process. The Comprehensive Planning Act, 87-749, and the Health Planning and Resources Development Act, 93-641, require local health planning bodies to be consumer dominated and to function with consumer representation at all levels. Disregarding these requirements, the Health Services Committee reviewed the project with two members present -- both physicians. The meeting, which lasted for two hours, consisted of questions directed to the director and president of the HMOBR. Although the two projects were approved, the committee felt that they could not vote on HMOBR since there were not enough members present.

(II) Reactions of the members of the HSA to the HMO concept can be gleaned from the grounds stated by the Planning Council for recommending disapproval of the HMOBR application:

(1) The study did not adequately justify the need for an HMO;

(2) The application was poorly prepared with inadequate information in some aspects and misinformation in other portions of the grant;

(3) The proposed HMO represented probable duplication of services since another HMO was being developed by Blue Cross and Stanocola.

To substantiate HMOBR's failure to demonstrate a need for an HMO, the HSA argued that HMOBR was merely proposing an alternative service delivery system which assumed the inadequacy of the present system. However, it was not felt that this inadequacy was demonstrated in the application. The situation was constrained with the Kaiser-Permanente Plan in California, which was developed because medical services were unavailable. Since this was not the case in Baton Rouge, the need for an HMO was doubted.

The second criticism faulted the application for data deficiencies. However, the HSA was uncooperative in providing health related demographic data. The Council was subsequently furnished with additional answers relating to the areas in question, some of which had been included in the document before the Council. The alleged inadequacies included the absence of a definition of primary care physicians, information on how the HMO would serve medically indigent population, how the HMO would relieve the shortage of primary care physicians, the absence of a list of community needs and how the HMO would address them, and a demonstration of the inadequacy of the existing system.

The third basis of disapproval concerned the duplication of services posed by the HMOBR and Stanocola-Blue Cross HMP. The assessment ignored the significant differences between the plans, the most important distinction being that HMOBR is seeking federal qualification. In addition.

noting the mere existence of a similar system did not address the question of whether the community could support the two operations. HEW, in approving the application, stated its opinion that HMOBR was feasible, and refuted the assumption that more than one HMO in a community implies duplication of services.

Community Health Care, Inc.
615 Anderson Building
12th and O Streets
Lincoln, Nebraska 68508
Stephen R. Tiwald
Executive Director

In August, 1975, Community Health Care, Inc. (CHCI) sent its HMO Planning Grant Application to DHEW and to the Southeast Nebraska Health Planning Council (SeNHPC). Following its usual procedures, SeNHPC established a multi-disciplinary Project Review Task Force to conduct a detailed examination of the proposal. Task Force members were: J.H. Hopkins, Bankers Life Nebraska; Harold Norby, Tabitha Home; John I. Wise, Dorsey Laboratories; Richard Marshall, D. D. S.; Don Penney, actuary from Stennes and Associates; Leonard Jennings, Lincoln Community Services; and Sue Scott, homemaker. Over a period of several weeks, the Task Force met five times and conducted a public hearing. It concluded its review by voting six to one to recommend approval of the application; the lone dissenter was Dr. Marshall. The SeNHPC staff recommendation was also positive.

In September, 1975, the SeNHPC Board of Directors deliberated and voted against accepting its Project Review Task Force's positive recommendation. Voting in favor were three consumer members; voting against were the seven providers and four of the consumer members; abstaining were four consumers, three of whom were CHCI Board members who did not vote because of the conflict of interest principle, and the acting chairman; twenty-three members were absent. Shortly thereafter, the CHCI Board of Directors decided to reconsider and therefore it withdrew its proposal at least temporarily from consideration by DHEW.

Over the winter and spring of 1976, CHCI did further study. During this time, results became available from a Lancaster County community attitude survey conducted by the University of Nebraska-Lincoln Bureau of Sociological Research which showed considerable dissatisfaction with the present health care system and significant support for the development of a health maintenance organization.

The CHCI Board felt that the survey findings were an additional reason to continue its effort to establish an HMO in Lincoln. After updating and improving the proposal, CHCI again submitted an HMO Planning Grant Application to DHEW and to SeNHPC in May, 1976. Again, the SeNHPC established a Project Review Task Force, this time composed of J. H. Hopkins, Bankers Life Nebraska; Harold Norby, Tabitha Home; Richard Marshall, D. D. S.; Dale Karnopp, Administrator, York General Hospital; George Rejda, Professor of Economics, UN-L; Carolyn Massey, homemaker;

and Marge Bush, homemaker. This Task Force met four times and conducted a public hearing. It concluded its review by voting five to one to recommend approval of the application; Dale Karnopp voted negatively. Once again, the SeNHPC staff recommendation was positive.

In late June of 1976, the SeNHPC Board of Directors voted eleven to ten against accepting its Project Review Task Force's positive recommendation. Voting in favor of the positive recommendation were four providers and six consumers; voting against were eight providers and three consumers; there were two abstentions; nineteen SeNHPC members were absent.

This was the last meeting of SeNHPC. Its successor organization, the Southeast Nebraska Health Systems Agency (SeNHSA), which was composed of many of the same individuals, held its first meeting immediately following the SeNHPC meeting. The SeNHSA decided to also vote on the project, although its action would not be the official local health planning agency comment. By a vote of ten to seven the SeNHSA voted to not accept the Project Review Task Force's positive recommendation. Voting in favor of the positive recommendation were three providers and four consumers; voting against the positive recommendation were seven providers and three consumers; there were two abstentions.

The CHCI Board of Directors felt that the SeNHPC and SeNHSA votes were so close that their results were not conclusive statements of local opinion on the topic of HMO development in Lincoln. Knowing that the local health planning agencies' comments did not constitute approval or disapproval, the CHCI Board of Directors decided to not withdraw the HMO Planning Grant Application from consideration by DHEW. After its review, DHEW decided in August, 1976, to make the grant award.

In late November, 1976, the SeNHSA voted to request an explanation from DHEW of why it had proceeded to award the grant. In a three-page letter from Dr. Holman R. Wherrett, Regional Health Administrator, DHEW responded with its reasons which included the following:

1) The SeNHPC staff report and the Task Force report recommending favorable review and comment used the established criteria for review. Positive comments indicated by the record were also received by representatives of Blue Cross, Bankers Life, employers, consumers, labor and elected officials of Lancaster and Lancaster County. An absence of these criteria was apparent in the final review and comment of the SeNHPC Board.

2. Twenty-three members attended the Board meeting. The acceptance of the majority Task Force report failed on a vote of 10 to 11; with proponents of the report abstaining due to conflict of interest. There was voting by members who could be considered as being in competition. In addition, letters of support from absent board members were later received.

3. The official review of two other Nebraska agencies was positive (The State of Nebraska Office of Comprehensive Health Planning and the Office of Planning and Programming).

4. The provisions of the HMO Act of 1973 and the concern of Congress for review and comment and the possibility of local provider interests thwarting the development of alternative delivery systems.

5. A misunderstanding by local provider representatives that the HMO Act was intended to provide for the medically underserved; and the statement by these representatives that if the HMO did not use federal support there would be no objections.

6. An acceptable application from a consumer based, non-profit corporation with endorsement from labor, employers, third party payors, and city and county elected officials, and with acceptable physician input was convincing that the objectives of a planning grant could be reached.

7. SeNHSA's review activity did not include approval/disapproval authority, but only review and comment authority.

CHCI's Initial Development Grant Application was received by the SeNHSA on July 25, 1977. On September 21, 1977, the Project Review Task Force recommended disapproval of the application. The Board of Directors accepted the majority report of the Project Review Task Force by a 16-8 vote on September 28, 1977. CHCI's Initial Development Grant Application had been accepted by DHEW on August 23, 1977. However,

On October 27, 1977, the State of Nebraska's Designated Planning Agency (DPA) sent a letter to SeNHSA in response to the latter's recommendation of disapproval. This letter refuted the major objections presented by the SeNHSA's Project Review Task Force and upon which it based its negative recommendation. The Task Force had a total of 10 objections to the CHCI application. The following discussion outlines

seven of those and includes the Task Force's comments and the DPA's responses:

1. The Task Force alleged that the project was inconsistent with the priorities established in Public Law 93-641, concerning the development of multi-institutional systems which promote the coordination and consolidation of institutional health services and the sharing of support services necessary to all health institutions. DPA advised the Task Force that, while the HMO might be inconsistent with those stated objectives, it was consistent with others including the priority to develop medical group practices and HMO's.

2. The Task Force believed that the HMO would not serve those with the greatest health care needs in the community. DPA noted that through open enrollment, some individuals with the greatest health needs would be enrolled in the HMO.

3. The Task Force stated that the HMO would duplicate existing health resources. DPA disagreed, however, stating that unnecessary duplication would not result.

4. The Task Force claimed that the application failed to identify physicians who would serve the HMO as primary care physicians and those willing to offer specialty services. In addition, it questioned the applicant's ability to attract new resources into the area. DPA responded that the HMO had submitted a list to DHEW of physicians willing to offer specialty services. (The application contained three signed letters from physicians for the primary care staff, meeting the requirements of HMO Planning Phase regulations). Since the HMO stated its intention to recruit physicians on a nation-wide basis, new resources would, in fact, be attracted to the area.

5. The Task Force was concerned with the HMO's potential to attract physicians away from non-metropolitan areas. The DPA pointed out, however, that HMO's could not be held solely responsible for the maldistribution of physicians. It noted that HMO's were not the only potential competitors with non-metropolitan areas -- hospitals also share that characteristic.

6. The Task Force felt that the HMO had not demonstrated that it would achieve cost containment goals. DPA replied that the inflationary trend of medical costs was a motivating factor in the promotion of HMO's. Substantiation of the HMO's ability to contain costs was based on operating data of HMO's nationwide.

7. The Task Force cited the lack of major consumer community support as another reason to disapprove the application. The DPA staff concluded, however, that adequate support was demonstrated in the application by the inclusion of 26 letters from employers, labor leaders, and government officials expressing approval and interest in CHCI. These groups represented 68,000 employees and their dependents.

Consistent opposition from the local medical society to HMO development is evidenced by the attached letters to the HMO Project Review Task Force.

E. L. GORTHEY, M.D.
PRESIDENT
R. F. MUELLER, M.D.
PRESIDENT ELECT
H. E. REESE, M.D.
PAST PRESIDENT
J. T. McGREER III, M.D.
SECRETARY-TREASURER
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LANCASTER COUNTY MEDICAL SOCIETY
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EXECUTIVE COUNCIL
L. J. GOGELA, M.D.
W. T. GRIFFIN, M.D.
O. R. HAYES, M.D.
L. R. LEE, M.D.

June 16, 1976

TO: HMO Planning Grant Review Task Force

FROM: Board of Trustees, Lancaster County Medical Society

On September 18, 1975 the Southeast Nebraska Health Planning Council voted to not approve a federally financed planning grant for an HMO in Lincoln, Nebraska. The main reason for this rejection was the fact that the federal monies earmarked for HMO's and HMO planning was to be funneled to the high priority of medically underserved populations. Evidence then and evidence now indicates that it is indeed questionable whether Lincoln, Nebraska and Lancaster County Nebraska is medically underserved. We would like for you to consider the following:

Medical facilities, medical care and medical planning in Lincoln are excellent.

Evolution of medical care in Lincoln is steadily progressive and responsive to community needs indicated by the fact that since May of 1975 eighteen new physicians have started practicing medicine in Lincoln, Nebraska.

The use of tax money to support ventures into competition with groups which have been exposed to the risks of the market place is questionable. We must realize that government money can not do all things for all people. The cost of running local, state and federal governments has increased from $63.3 billion in 1950 to $579.5 billion in 1975 - an increase of over 900%. Ironically, with the 200th birthday of our country close at hand it is evident that government has overly involved itself in the lives of its citizens.

Proponents of an HMO organization indicate that an HMO can stabilize and/or reduce the cost of health care. Between fiscal year 1950 and 1974 the cost of personal health care went from $10.4 billion to $90.3 billion-of this increase

----about 46% or $36.8 billion can be attributed to inflation.
----another 15% or $12.3 billion is the result of population growth.
----the remaining 39% or $30.8 billion is due to the publics increased use of medical services and to a wide variety of lifesaving, but often costly medical techniques.

How an HMO, or any other health delivery agency for that matter, would be immune from these cost increases is difficult to understand.

Therefore, in view of the above information, the Board of Trustees of the Lancaster County Medical Society would like to respectfully ask that the HMO Planning Grant Project Review Task Force recommend to the Board of Directors of the Southeast Nebraska Health Planning Council and the Southeast Nebraska Health System Agency that the request by the Community Health Care Association for a $125,000.00 HMO Planning Grant Application be denied. The need for and the utilization of an HMO in Lincoln, Nebraska has not been established and it is extremely doubtful that such can be established in the future.

Thank you for your time and consideration.

R. F. MUELLER, M.D.
PRESIDENT
[illegible]
PAST PRESIDENT
L. GORTNEY, M.D.
PAST PRESIDENT
T. MERCER III, M.D.
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EXECUTIVE [illegible]
M. A. EINS, M.D.
A. W. DOWMAN, M.D.
D. W. HAYES, M.D.
L. W. LEE, M.D.

August 11, 1977

Dear Community Health Care, Inc.
HMO Development Grant
Project Review Task Force:

The Board of Trustees of the Lancaster County Medical Society would like to respectfully comment on the application of Community Health Care, Inc. (CHCI) for a one million dollar development grant from the federal government.

The position of the Lancaster County Medical Society is a matter of record. We continue to support community efforts directed towards unnecessary and costly duplication of facilities and services while protecting the freedom of choice for every patient. The CHCI proposal would defeat these objectives.

The current CHCI proposal contains the same flaws previously identified by the local health planning agency. For example, the proposal contends that its "two-tier rate structure (is) comparable to premiums paid for conventional employee benefit insurance plans." Even if we acknowledge this debatable point, the rate structure will still be underwritten by an expense of $1 million in a federal grant and over $2 million in loans. It seems appropriate to ask where the savings are and what revenue will be available when the loan funds are exhausted? Also, what is the proposed source of the loan funds?

On June 23, 1976 the Southeast Nebraska Health Planning Council Board of Directors and the Southeast Nebraska Health Systems Agency Board of Directors wisely and appropriately voted to not approve a CHCA HMO Planning Grant for $125,000.00 from the federal government. It is indeed unfortunate that these actions are rendered moot by a federal law (P.L. 93-641) which allows federal officials to overrule decisions of local and state agencies. This law is presently being challenged legally by the states of Nebraska and North Carolina and the American Medical Association in Raleigh, North Carolina.

Respectfully,

R. F. Mueller, M. D., President
Lancaster County Medical Society

Rutgers Community Health Plan
57 U. S. Highway #1
New Brunswick, New Jersey 08901
Roger W. Birnbaum
Executive Director

The Rutgers Community Health Plan (RCHP) is an independent, non-profit organization with a Board of Trustees composed of representatives from area industry, organized labor, community organizations, the medical community, and consumers enrolled in the Plan.

RCHP is a State Certified Health Maintenance Organization. This means that the Plan was subject to a review process by, and continues to be monitored by, the State Departments of Health and Insurance. Under the provisions of N. J. HMO Law (P. L. 1973, Chapter 337, C. 26:2J-1), these Departments must receive assurances regarding the availability and accessibility of required resources; quality assurance programs; accounting, reporting and auditing systems; financial soundness; protection of members in the event of cessation of operations; enrollees' participation in policy determination; and the maintenance of a complaint procedure.

RCHP is a Federally Qualified Health Maintenance Organization. This means that the Plan was subject to an extensive series of requirements including and going beyond those of the State of New Jersey noted above. RCHP initially planned its program under Certificate of Need #00443-12-13, awarded November 15, 1972. Certificate of Need #01580-12-11 was awarded August 15, 1975, for the construction of the initial 10,000 square feet of the proposed 35,000 square foot ambulatory facility.

In providing capacity for its ultimate membership objective of 35,000 enrollees over a three-year period, RCHP developed a two-stage facility plan to minimize fixed costs during early months of relatively low membership. Construction on the second state was to commence when membership reached a level of about 8,000 and become available at a membership level of about 14,000. This facility program has been consistently outlined in all Certificate of Need Applications and Federal HMO development grant applications approved to date.

The experience of the Rutgers Community Health Plan in making its way through the various stages of the review process raises a number of questions relative to whether the process as currently operating serves the intended objectives of the legislation.

In the interests of providing feedback that might be useful as the health planning process further evolves, the step-by-step process experienced by RCHP's attempt to secure Certificate of Need approval is briefly summarized below:

1. Somerset County Advisory Committee - In mid-November 1976, the Somerset CAC met to review the RCHP Certificate of Need Application. The applicant was not notified of or invited to attend the meeting. The Somerset CAC recommended deferral of the Certificate in part because "it is premature, the need for expansion has not been demonstrated" and, "according to figures supplied enrollment has not met projection." Since RCHP had in fact met and far exceeded projection, and has demonstrated a significant volume of potential membership it does not have the capacity to serve, the County Committee's action is puzzling. RCHP has no information regarding the data made available by HSA staff, the composition of the Committee in attendance on the day of the meeting or what the nature of the discussion and vote was; specifically, was there a majority of consumers board members in attendance, were providers invited and permitted to speak, etc.

2. Middlesex County Advisory Committee - On November 30, 1976, the Middlesex CAC reviewed the RCHP Certificate of Need Application. The applicant was invited to appear and did attend. Area providers were all sent notices by the Chairperson encouraging them to appear because of their vital interests involved. They attended in force. Only eleven Board members were present, a substantial majority of them providers, raising questions regarding whether requirements of both quorum and consumer representation were satisfied. The ad hoc format announced by the chairperson provided for the applicant to present its case in ten minutes with "opponents" having ten minutes to respond. There was no opportunity for the applicant to rebut the charges made by its opponents. The adversary format, together with the opportunity given to provider opponents to make various uniformed, unfounded, and ofter irresponsible comments, served to put the applicant on the defensive with its credibility under question, rather than to elicit information for the Committee's consideration. It very much appeared to be a forum where community providers were telling Committee providers what they wanted to hear. The Middlesex CAC recommended denial of the Certificate.

3. Regional Review Committee of the Central Jersey Health Planning Council - On December 1, the evening following the Middlesex CAC meeting, the Regional Review Committee of the Central Jersey Health Planning Council reviewed the RCHP Certificate of Need Application. The applicant and several area provider interests attended. Once again, the applicant and opposing interests presented their arguments, but with more of an opportunity for additional discussion between committee members, applicant and opponents. Consumer members were considerably more evident than at the prior evening's meeting. The Regional Review Committee recommended endorsement of the Certificate (the vote was 8-3 with 1 abstention due to conflict of interest), citing the following as need factors:

> Present enrollment and projected growth demonstrate need for additional square footage. As of January 1, 1977, the enrollment will be 8,700 individuals; by July 1977 the projected enrollment will be nearly 13,000 and by July 1979, the projection is for 35,000 individuals.

4. Central Jersey Health Planning Council - On December 8, the Central Jersey Health Planning Council reviewed the RCHP Certificate of Need Application. The meeting attracted a wide audience of provider interests and some consumers. In order to keep the discussion within a reasonable time frame, the Council adopted a format it utilized at the prior month's hearing of a controversial abortion clinic: five minutes for the applicant to present, and 15 minutes each for "opponents" and "proponents", with alternating 2-2½ minute presentations by each side. "Opposing" views were presented by representatives of the County Medical Society, the Osteopathic Association, local physicians, and two area hospitals which are not currently RCHP participating hospitals. Several consumers and a representative of the State Health Department, as well as the applicant, spoke as "proponents". There are a number of problems with this format: Once again, the adversary nature of the proceedings is counterproductive to the need to elicit information. In fact, the requirement for speakers to declare themselves as either "proponents" or "opponents" provides no appropriate platform for objective, factual materials to be made available (e.g., by the State Health Department). The applicant is provided an inadequate

amount of time to present his case and is then put on the continual defensive in an inappropriate debating arena. To respond to inaccurate, unfounded, and often irrelevant and irresponsible charges made by "opponents" serves to legitimatize such charges; on the other hand, not to respond to them is to leave seeds of doubt in the minds of Council members, presenting the applicant with significant credibility problems. At no time were issues irrelevant to the demonstration of need ruled out of order. Specific criteria to be used as guidelines by HSAs in reviewing HMO Certificates, although presented by the HSA's executive director, were totally ignored.

The objective of eliciting information would be far better served through a question and answer format where the chairperson gives the applicant (and/or Council staff) an opportunity to respond to responsible, relevant questions. Permitting unsupportable charges presented by "opponents" inconflict of interest with the applicant to stand on the record represents a total subversion of the intent of the certificate of need process.

The Council failed to endorse the recommendation of its Regional Review Committee and recommended deferral. The vote for deferral was 12-10 with one abstention and two members not voting because of possible conflict of interest. Other area providers on the Council did not see fit to disqualify themselves because of possible conflict of interest. Some consumer members of the Council, concerned with the outcome, specifically asked that the endorsement of the Regional Review Committee be included as a minority report.

5. Mercer County Advisory Committee - On January 4, 1977, the Mercer CAC reviewed the RCHP Certificate of Need Application. The Committee recommended endorsement by a vote of 6-4 (with 1 abstention), specifying a number of qualifications.

6. State Review Committee - On January 18, 1977, the State Review Committee unanimously supported RCHP's Certificate of Need request.

7. State Health Coordinating Council - Late in January, the SHCC recommended that a Certificate of Need be granted to RCHP to expand its facilities.

Group Health Association, Inc.
2121 Pennsylvania Avenue, N. W.
Washington, D. C. 20037
Louis Segadelli
Executive Director

Group Health Association, Inc. (GHA) is a federally-qualified prepaid group practice HMO which provides health care services to 103,500 enrollees in the Washington metropolitan area. The enrollee population is distributed as follows: approximately 50,000 enrollees live in the District of Columbia; approximately 37,000 reside in Maryland equal numbers located in Prince Georges and Montgomery Counties; and the remainder, 16,500 enrollees, live in northern Virginia (most of them in Fairfax County). Hospital care is provided in a number of metropolitan area hospitals.

In recent years, GHA has had two major problems with local planning agencies. The first problem concerned their application to the District of Columbia Planning Agency for a certificate of need to build a hospital and primary secondary care center for the use of its enrollees. Because the success of this application would eliminate GHA's existing D. C. ambulatory facility and because of the growing number of GHA enrollees living in Prince Georges County, GHA also submitted a proposal to establish an ambulatory medical facility in the county. This latter proposal will be discussed here.

Proposal to establish an ambulatory medical facility

In January, 1977, GHAA submitted an application to the Southern Maryland Health Systems Agency (SMHSA) in order to obtain a Section 1122 certification review. The application proposed the development of a satellite clinic in Prince Georges County because GHA had determined that improved access to a GHA facility was necessary for GHA enrollees living in the county.

On February 2, 1977, a staff officer submitted a report to the SMHSA Project Review Committee recommending approval of a one year Section 1122 certification. This report made, among others, the following observations:

> The particular clientell served by the proposed center is not served by nearby facilities but must travel into the District of Columbia or Hyattsville for services. If the GHA plans for closing their D. C. facility entirely and moving tertiary functions into a hospital is realized, subscribers will have no ready access to medical services.
>
> The Southern Maryland HSA is believed to be a physician-deficient area leading to gaps in the medical services delivery system. GHA makes use of physician (pick up on page 2)

> extenders . . . to reduce costs and expand service offerings. In this regard it functions as a model for providing ambulatory care. By nature of its organization, it provides competition to other providers of health services in Southern Maryland but because of the shortages of providers the impact of this organization on the other providers would be negligible.

At the February 9th meeting of the SMHSA, the Project Review Committee advanced the approval recommendation to the full board. There was considerable public comment in opposition to the proposed project, all such opposition coming from providers located in Prince Georges County.

The negative comments included the following: the president of the Southern Maryland Hospital Center did not understand the "sudden desire" for adding health services in predominately rural area, citing an inadequate population based for additional medical services; it was stated that the GHA facility would be a "dramatic encroachment" into the market of the Southern Maryland Hospital Center Ambulatory Facility; and it was stated that there were 80 physicians in the County who would rather establish their own IPA-type HMO "and offer choice of physicians and continue the free-enterprise system." After lengthy discussion, the board voted to resubmit the application to the Committee.

The Project Review Committee scheduled a special meeting on February 23, 1977. This meeting was attended, by, in addition to the Committee members, approximately 100 persons. However, the minutes of the meeting note that the providers who voiced opposition at the SMHSA meeting on February 9th were "noticeably absent". The Committee, after hearing several speakers testifying in favor of the project, voted 7-2 to recommend approval of the GHA application.

The governing body of the SMHSA met again on March 9, 1977. The Project Review Committee moved the approval of a one year federal Section 1122 certification. After discussion, the motion was amended to read: "the recommendation that Group Health Association be issued a one year Federal Section 1122 Certificate and that a detailed list of services proposed to be offered at the site be appended." So amended, the motion was carried by a narrow margin with 13 members affirming, 10 opposing, and 2 members abstaining.

Health Care Plan, Inc.
664 Ellicott Square Building
Buffalo, New York 14203
Arthur Goshin, M. D.
Project Director

The Western New York area is fortunate in having a health systems agency which is well-organized and progressive in its concern for the efficiency and effectiveness of the health delivery system as well as for innovative program development. The agency has had little previous experience with HMO-type organizations, inasmuch as the Health Care Plan and the Western New York Health Planning Corporation, both developing HMO's, are the first in the region. Because the HSA staff and members had a minimal exposure to HMO issues, the agency sponsored a one-day educational session in which federal and state officials as well as HMO executives from other parts of the State were invited to discuss relevant matters. Such sessions are valuable and should be encouraged.

The Health Care Plan has observed certain difficulties with the planning and review process, however. In a recent series of events concerning the HSA review and comment on the initial development applications of the two developing HMO's, important deficiencies in the structure and process of such reviews were encountered.

The Health Care Plan and the Western New York Health Planning Corporation applied for federal initial development funds at the same time and will serve partially overlapping geographical areas. By the usual federal planning parameters, the total area (Erie County and parts of Niagara County) is capable of supporting more than one HMO. At one time in their respective development, the two organizations considered the potential for merger but through a course of discussions concluded that an organizational merger was not feasible. The HSA reviewed two independent applications.

The staff of the HSA is open to admit that, given time constraints and staff expertise, the only feasible review of such applications is a very superficial one. Both applications are approximately 1,400 pages in length and contain financial and statistical data which could not be adequately reviewed in detail. Moreover, it was not possible for the staff to discern the subtle, underlying differences and objectives. Although the HSA staff was involved in the previous merger discussions, the impracticality of such a move was not fully appreciated. At the same time, the HSA's and state regulatory offices are operating under a criteria of reducing or avoiding non-duplication of service. Hence, the two applications which proposed to

impact on the same geographical area were interpreted as duplication of service. Although previous HSA reviews have demonstrated a lack of primary care resources and even though no other HMO organizations currently exist or are under development in the area, the criteria usually applied to hospitals and nursing homes were applied to HMO development. The recommendation which the HSA staff initially made was that the two organizations merge and that the one organization be funded.

The process of subarea and executive committee review yielded a different interpretation in which the objective of maximizing financial resources to the area became more important. The executive committee recommended that both independent organizations be funded.

At the conclusion of the DHEW review, the regional office notified both organizations that it intended to fund only one organization. This action on the part of DHEW was apparently taken without notifying or consulting the HSA. The HSA executive committee met again and agreed to maintain it's initial recommendation for the funding of both organizations.

The process which Health Care Plan has undergone demonstrates clearly that many HSA's do not have appropriate staff expertise to deal with the unique issues of HMO development. The criteria outlined in the federal regulations are too general and can, in some cases, be misleading. There is a definite need for more specific criteria and for criteria which are relevant to the major issues being addressed by HMO development.

Valley Health Plan
P. O. Box 227
441 West Street
Amherst, Massachusetts 01002
F. Q. Rice
Executive Director

Valley Health Plan (VHP) is a HMO program grantee. In January 1976, VHP submitted its application for an initial development grant to the Western Massachusetts Health Planning Council (WMHPC) for review. An adversary relationship quickly developed between VHP and WMHPC. From this experience VHP's Executive Director drew the following conclusions:

"1. Neither the staff nor the sub-area advisory council understood anything in any depth about HMOs. What they thought they knew was erroneous or severely biased for the most part.

2. Many of the consumer members of the council, reflecting the motivations that led them to volunteer in the first place, had strong social action agenda of their own. They could not accept any intrinsic value in an organization that valued fiscal solvency or saw its role as different from serving the poor as its top priority.

3. Allied to this was the lack of pragmatism on the part of much of the council. Few were willing to acknowledge the necessity of the politics of compromise in the difficult task of HMO-building. I simply couldn't get through why the physician groups interested in joining VHP did not feel they could donate their time, or why they would not leap from virtually no formal quality assurance program to external view.

4. Finally, I am afraid that the HSAs continue to be greatly influenced by the health care establishment, who fear the change HMOs threaten. This is both by their direct representation on the councils, but also by their studied courting of staff members. Underpaid, young planners can all too easily be turned just enough in their perspectives to distrust things that they don't really understand, such as HMOs. This happened in our situation."

Other Plans Blocked by HSAs

The following organizations encountered serious planning difficulties with the local HSA during the grant funding process and have not become operational:

1. North Central Connecticut HMO
   275 Broad Street
   Windsor, Connecticut 06095

2. The Gulf Coast Family Health
   Foundation, Inc.
   912 Convent Avenue
   Pascogoula, Mississippi 39567

3. Southwest Medical Plan
   Suite 1111
   7430 Louis Pasteur Drive
   San Antonio, Texas 78229

4. Southeastern Montana Health Plan
   2101 Clark Street
   Miles City, Montana 59301

Documentation of the problems encountered by these organizations is on file with HEW's Division of HMO Development, 5600 Fishers Lane, Rockville, Maryland.

Mr. Rogers. Thank you very much, Mr. Seidman, for a direct statement and specific suggestions. You have made some very good points. Dr. Carter.

Mr. Carter. Thank you, Mr. Chairman.

I want to compliment you on your presentation. I think it is one of the best I have heard.

Mr. Seidman. Thank you very much.

Mr. Carter. One thing you have said which is quite meaningful and which many have left out is that cost effectiveness should be considered along with cost containment. There are many devices which may save in the long run. I point specifically to the corpuscle-counting machine for blood counts.

A capital expenditure may save money and time. We must take this into account. I want to compliment you for bringing that out.

Furthermore I would think that, if we had to discontinue hospitals or decertify hospitals, then those who lose employment should be taken care of. I agree with that concept. I think your statement is very meaningful. Thank you, Mr. Chairman.

Mr. Rogers. Thank you, Mr. Seidman. We appreciate your presence as well as that of Mr. Shoemaker and Mr. McLaughlin.

Mr. Seidman. Thank you.

Mr. Rogers. The next witnesses will be a panel of osteopathic representatives, Dr. Philip Adler, president of the American Osteopathic Association, director of the AOA Washington office, and Mr. Gerson Cooper, administrator, Zieger Osteopathic Hospital. We welcome you gentlemen to the committee. Your statements will be made part of the record in full [see p. 588]. If you could highlight your statements for us it will be helpful to the committee. You may proceed.

STATEMENTS OF GERSON I. COOPER, CHAIRMAN, GOVERNMENT RELATIONS COMMITTEE, AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, ACCOMPANIED BY MICHAEL F. DOODY, PRESDENT; AND PHILIP ADLER, D.O., PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION, ACCOMPANIED BY JOHN P. PERIN, DIRECTOR, WASHINGTON OFFICE OF AOA

Mr. Cooper. Thank you, Mr. Chairman. Mr. Chairman, members of the subcommittee, I am Gerson I. Cooper, chairman-elect of the board of trustees of the American Osteopathic Hospital Association and vice-president for administration of Zieger Osteopathic Hospital in Detroit and Botsford General Hospital—Osteopathic—in Farmington Hills, Mich. With me today is Michael F. Doody, president of the association.

The American Osteopathic Hospital Association maintains its headquarters in Park Ridge, Ill., with an office in Washington, D.C., and represents the Nation's 200 osteopathic hospitals. These institutions serve as the primary institutional care facilities for those patients who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in this country.

Osteopathic hospitals support sound health planning by providers, consumers, and public agencies that will provide for community health needs in a responsible and effective manner.

The profession and its hospitals are not asking to be exempt from the planning law nor are we suggesting a change in the law to preclude the necessity of applying for a certificate of need. Our primary concern relates to section 1532(c) of Public Law 93–641, which sets forth minimum criteria the States must adopt in their certificate-of-need programs.

These criteria do not include language to assure that patients will be guaranteed their right to select the provider of their choice. This can be accomplished by an amendment to section 1532(c) which would include language mandating equal consideration of the need and availability of osteopathic and nonosteopathic facilities and services within a community.

I would like to emphasize that we do not wish to be exempted from the certificate-of-need provisions but we are strongly urging a change which will provide for consideration of the need for and availability of osteopathic services and facilities in the community for those individuals who seek them.

The American Osteopathic Hospital Association is vitally concerned with the distinct identification of osteopathic facilities and services. It is our position that in any cataloging of health services and in any assessment of their appropriateness, osteopathic services and facilities must be identified as such and not casually lumped together with others.

Osteopathic hospitals are fully licensed, accredited and approved medical care institutions that provide a full range of medical services to their communities. The care of patients in osteopathic hospitals is a logical extension of the care available in the offices of the osteopathic physician.

These hospitals are staffed with osteopathic generalists and specialists who utilize structural diagnosis and manipulative therapy along with all of the other traditional modalities of diagnosis and treatment to care effectively for their patients.

Osteopathic medicine practiced in osteopathic hospitals offers something more, not something else.

Mr. Chairman, there is little doubt that osteopathic physicians and hospitals have encountered discriminatory practices in their efforts to provide needed health services to the communities they serve. Our written testimony documents many specific examples of same. I will cite briefly from personal experience:

Zieger Osteopathic Hospital is a 160-bed inner-city institution serving largely an indigent and aging population. Thirty-five years old and jerry-built, it is plagued with a multitude of physical plant deficiencies that can be corrected only through a replacement project. To complicate matters, southeastern Michigan, especially the city of Detroit, is an overbedded area. We started merger explorations in 1968.

More recently, and for the past 2 years we have been engaged in formal and intensive negotiations which seem now to be bearing

fruit. On just this last November 3 articles of combination were signed by ourselves and two other inner-city osteopathic hospitals, which collectively comprise approximately 700 beds.

It is the intent to merge these facilities and to plan a replacement project. It will probably provide about 300 to 325 beds in an integrated, sophisticated, multidiscipline system. The certificate-of-need request just for the merger was filed shortly after the normal signing.

Normally the application of certificate-of-need to merge would be what is termed a nonsubstantive review and has in the past met with virtually a rubber stamp, because, I think, it is universally recognized that the route of merger is perhaps one of the most cost-effective and quick ways of effectuating reductions in unnecessary beds.

The Comprehensive Health Planning Council of Southeastern Michigan, our local HSA, no more than 8 weeks prior to considering our certificate of need request, ruled in a similar project involving three medical hospitals on the east side of Detroit, on a nonsubstantive basis and in a time frame of about 4 weeks. The director of the HSA ruled in our case that a substantive review was indicated, thereby adding, in a critical period in our development, approximately 2½ months' delay.

The Michigan Osteopathic Hospital Association took issue with this decision in a letter which is contained in our written testimony. I would like to quote very briefly from it:

> It is inconceivable that this kind of support

and it refers to the community support, which was very broadbased—

> and considering the fact that this certificate-of-need request is solely for the purpose of merging and seeks no expenditure of capital funds or change in beds or service programs, that the Comprehensive of Health Planning Council of Southeastern Michigan could determine that the review should be anything other than on a nonsubstantive basis.
>
> It is simply bewildering that, with general agreement that mergers hold out the best promise of a solution to overbedding, duplication of services and most containment in general and with both State and Federal legislation now pending which would encourage mergers, that CHPC–SEM would do anything to hamper, discourage or delay these efforts in its planning area.

The postscript is that on this past Wednesday morning the planning and implementation committee of the local HSA met and endorsed the project by unanimous vote. We have every reason to believe that, at its executive committee meeting on February 9, the HSA itself will endorse it. We have received strong indication from the State agency, that they, too, will approve the project.

The problem that was encountered was that, after many years of negotiations, it was necessary for us to be able to show our constituency, the hospital boards, the medical staffs in three hospitals and employees, that there is positive, resolute action taken.

A residual disappointment is that, in reply to the letter that was directed to Mr. Carroll, who is executive director of the local planning agency, an answer was written by Mr. Carroll. I have also enclosed a copy of that letter. Our concern relates to the last paragraph:

> Finally, I feel I must comment on the nomenclature used in your letter. As I have frequently publicly stated, I can find no basis in either Federal or State

statutes for distinguishing hospitals as either "allopathic" or "osteopathic." Some hospitals are staffed predominately by physicians with degrees and licensure as Doctors of Medicine; others are staffed predominately by physicians who have degrees and licensures as Doctors of Osteopathy. The physician staffing pattern does not, and should not, characterize a hospital as being either "allopathic" or "osteopathic." It is the position of this organization, and one which I have personally advocated for many years, that medical staff privileges should not be based on race, religion, creed, national origin, type of medical licensure, or any other factor extraneous to the ability of physicians to provide appropriate services to patients.

That is a very, very disturbing admission on the part of the director of a local planning agency.

In conclusion let me restate that we strongly support sound health planning. Here we are seeking only equitable consideration. We firmly believe that osteopathic hospitals fulfill a vital role in the delivery of health care and, if allowed to function and plan on an equal basis with all other hospitals, the ultimate beneficiary will be the communities we serve.

We strongly urge the subcommittee to favorably consider the language proposed in our written testimony. We thank you for the opportunity to testify on this matter. Mr. Doody and I will be pleased to answer any questions that you and members of the subcommittee might have. Thank you.

[Testimony resumes on p. 628.]

[Mr. Cooper's prepared statement and attachments follow:]



AMERICAN OSTEOPATHIC
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AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
Statement Presented to the House Interstate and Foreign Commerce Committee
Subcommittee on Health and the Environment
Views on Amending P.L. 93-641
February 1, 1978

This statement is presented by Gerson I. Cooper, Chairman-Elect of the Board of Trustees and Chairman of the Government Relations Committee, and Michael F. Doody, President, of the American Osteopathic Hospital Association, 930 Busse Highway, Park Ridge, Illinois 60068.

The AOHA maintains its Headquarters in Illinois, with an office in Washington, D.C., and represents the 200 osteopathic hospitals which are located in 28 states. These institutions serve as the primary institutional care facilities for those patients (individual consumers) who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in the country.

INTRODUCTION

The primary goal of sound health planning is to assure that high quality services are available, accessible and viable to the patient population. Public Law 93-641, the National Health Planning and Resources Development Act, requires each state to establish a certificate of need program which would set forth criteria for use by a state agency in evaluating all new institutional health services proposed to be developed or offered within the state.

Osteopathic hospitals strongly support the basic concepts of sound community planning by providers of health care, consumers and public agencies that will provide for community health needs in a responsible and effective manner. Section 1532 (c) of P.L. 93-641 sets forth minimum criteria the states must adopt in their certificate of need programs. These criteria do not, however, include language to assure that individual consumers/patients will be guaranteed their right to select the provider of their choice. We are not suggesting a change in the law with regard to the necessity of applying for and receiving a certificate of need. This can be accomplished by an amendment to Section 1532 (c) which would include language mandating consideration of the availability of both osteopathic and allopathic facilities and services within a community.

The AOHA is very concerned with the distinct identification of osteopathic facilities and services. It is important that any inventory of institutional health services, and in any comment on the appropriateness of health services, that osteopathic health services be identified as being osteopathic and not casually included in a single number or description of similar health services. It is important that any cataloguing of institutional health services recognize the fact that there are certain diagnostic and therapeutic health services unique to the osteopathic hospital.

What is an Osteopathic Hospital?

Osteopathic hospitals are fully licensed, accredited and approved medical institutions that provide a full range of medical services to their communities. They comprise an important and significant segment of the total health care industry.

Today the 200 osteopathic hospitals located in 28 states provide more than 23,000 beds for treatment of the sick and injured.

An estimated 825,000 patients are admitted to osteopathic hospitals each year, resulting in some 6.3 million patient days of care. In addition, the outpatient departments of osteopathic hospitals accept some 3.1 million patients each year for emergency and other ambulatory care.

The care of patients in osteopathic hospitals is an extension of the care available in the offices of the osteopathic physician (D.O.). An osteopathic hospital is staffed by a team of osteopathic physicians. There are many forms of discomfort and disease which are dealt with daily in all hospitals, in which osteopathic concepts introduce a distinction between allopathic and osteopathic approaches.

The osteopathic physician has an additional dimension to his training and practice which is not taught in medical schools giving M.D. degrees. The D.O. recognizes that the musculoskeletal system (the muscles, bones, and joints) make up over 60 percent of the total body mass. He also recognizes that all body systems, including the musculoskeletal system, are interdependent, and a disturbance in one causes altered function in other systems of the body.

This interrelationship of body systems is effected through the nervous and circulatory systems. The emphasis on the relationship between body structure and organic functioning gives a broader base for the treatment of the patient as a unit.

These concepts require a thorough understanding of anatomy and the development of special skills in recognizing (diagnosing) and correcting (treating) structural problems through manipulative therapy. The D.O. uses structural diagnosis and manipulative therapy along with all of the other more traditional forms of diagnosis and treatment to care effectively for patients and to relieve their distress.

Osteopathic medicine offers something more--not something else.

Osteopathic medicine is a second school of medicine in which the vast majority of the practicing osteopathic physicians are general practitioners, many of whom serve in rural or semi-rural areas. According to recent data, more than 65% of all the D.O.'s in the nation are general practitioners. Similar statistics show that only 15-20% of the M.D.'s in the U.S. are engaged in general practice. A more significant figure, however, is that of the total general practitioners in the U.S., more than 17% are D.O.'s. This is in a profession which currently comprises only slightly more than 4% of all the practicing physicians nationwide.

The federal government, state governments, and private and public health agencies have recognized osteopathic medicine as a separate but equal branch of American health care. As a result, osteopathic physicians have the same rights and same professional obligations as allopathic (M.D.) physicians.

The American Osteopathic Hospital Association maintains that the osteopathic profession and its continuing emphasis on general practice rather than medical specialization best serves the health care needs of the American public.

The Postdoctoral Education of Osteopathic Physicians

The postdoctoral education of these professional physicians is dependent upon the continued viability of osteopathic hospitals--more than 35% of which are involved in the post-graduate education of osteopathic physicians.

The accrediting agency for all osteopathic education is the American Osteopathic Association (AOA). The AOA has been so designated by the National Commission on Accreditation of the Office of Education, Department of Health, Education and Welfare. In both federal and state legislation, as well as in the Medicare and Medicaid statutes, the AOA is repeatedly recognized as the accrediting body for all osteopathic

education, and the osteopathic profession is recognized as a second school of medicine, separate and distinct from the allopathic school.

The AOA can only approve internship programs in those AOA accredited hospitals offering distinct osteopathic training based on the unique osteopathic philosophy. These institutions are subject to stringent inspection by the AOA and must meet their requirements to maintain accredited training programs. This training results in the production of a physician who can treat families, rather than a physician who restricts his practice to one specialty.

Millions of Americans have freely chosen to seek their care from osteopathic physicians and hospitals. The shortage of family practitioners in this country has caused the establishment of new colleges of osteopathic medicine, which are supported by the community in which they are located and in many cases by state and local funds.

Today there are 11 colleges of osteopathic medicine, 8 of which will be graduating students in 1978. The remaining three colleges will be graduating their first classes next year and in 1980. The number of projected graduates for the colleges over the next four years will increase from 963 in 1978 to more than 1200 in 1981.

Today, nearly 80 osteopathic hospitals (40% of the total number) are approved by the AOA for intern training. These hospitals currently have only 866 approved intern training positions. Taking into consideration that a number of graduates will enter federal service, there will be sufficient positions in osteopathic hospitals for graduates in 1978. However, in the coming years, the increasing number of graduates will place a critical burden on our institutions unless provision can be made to expand the teaching programs in qualified hospitals. As Secretary of Health, Education and Welfare

Joseph Califano stated in the preamble to the newly proposed National Guidelines for Health Planning on January 20:

> "Revisions made in the Standards should be helpful to those who are developing programs to prepare additional physicians and nurses for primary care. The importance of these programs and their extension are strongly supported."

Recent statistics compiled by our Association show that nearly half of the 200 osteopathic hospitals across the country are located in communities with populations of 50,000 or less. More than 30% of all osteopathic hospitals are located in communities of 20,000 or less. These figures indicate that our hospitals provide care to many smaller communities and further points to the necessity of the continuing viability of these institutions.

It is not difficult to see the very important relationship between the concept of certificate of need and the ability of the osteopathic profession to continue to educate physicians who will engage in general practice in the delivery of primary care to millions of Americans, especially in geographic areas of need.

Discrimination

It is feared that without provision for consideration of osteopathic facilities and services, osteopathic hospitals will not be allowed orderly growth and expansion where the need is justified. There is little doubt that there has been discrimination over the years against osteopathic physicians and hospitals in their efforts to provide needed health services to the communities in which they are located. A list of specific hospitals which have experienced discriminatory actions include: Art Centre Hospital Osteopathic in Detroit, Michigan; Tucson General Hospital in

Tucson, Arizona; Pontiac Osteopathic Hospital in Pontiac, Michigan; Sandusky Memorial Osteopathic Hospital in Sandusky, Ohio; Grand Rapids Osteopathic Hospital in Grand Rapids, Michigan; Flint Osteopathic Hospital in Flint, Michigan; and The Osteopathic Hospital Development Corporation of Detroit.

In Arizona on March 31, 1976, the Superior Court in Pima County ruled in Tucson General Hospital vs. James I. Schamadan, M.D. that "to construe 'public need' to mean the public in general as opposed to a segment of the population which desires or prefers services by an osteopathic physician is to construe it too narrowly. If a considerable portion of the public desires the services of an osteopathic physician, it is the court's opinion that the 'public need' requirement of the statute is satisfied." The decision went on to state that a certificate of need, previously denied Tucson General Hospital, an osteopathic institution, must be granted.

On August 5th, 1976 Rocky Mountain Hospital in Denver, Colorado received authorization for construction of a renovated and enlarged labor and delivery area and for the remodeling and expansion of the hospital's surgical suite from the Colorado Health Facilities Council. In a precedent setting decision for the state, the Council granted approval for a certificate of need on the basis that the hospital is an osteopathic teaching institution. The construction was necessary to maintain AOA accreditation as well as approval for intern/residency training.

Because of this past history, and in recognition of the unique and important role played by osteopathic hospitals, several state legislatures have given consideration to language that specifically requires separate consideration and evaluation of osteopathic hospitals in the certificate of need process. Thus far, the states of Oklahoma, Rhode Island, Florida and Iowa have enacted legislation along these

lines. In Ohio, the same effect was achieved through the regulatory process. And in Michigan, similar legislative language is very close to enactment.

Attached to this testimony, you will find citations of the language currently in force in these states.

Also attached, as Appendix B, you will find documentation of six representative cases of discrimination against osteopathic hospitals and physicians which serve to illustrate and reinforce the need for the type of language we are seeking. The first three examples you will find are from Michigan and Ohio. They point out the type of discrimination which can be and has been encountered with local health planning agencies. The fourth example is from Art Centre Hospital Osteopathic in Detroit and it delineates the kind of discrimination which is occasionally encountered with the state planning agencies. The fifth example is a case in which a physician encountered discrimination in his attempts to obtain privileges at a nearby allopathic facility. The sixth illustrates the concerns expressed by a very conscientious governing body of an osteopathic hospital regarding an arbitrary HSA decision which was only marginally passed and which could become policy.

The example cited from the Osteopathic Hospital Development Corporation of Detroit, although fully documented in the attachments, is worthy of summary here since it is a particularly representative example of the problems faced by osteopathic hospitals before planning agencies and it graphically illustrates the more subtle kinds of discrimination encountered.

On November 28, 1977, a publication entitled "Monday Comments from CHPC" carried an item dealing with the review of a proposed merger of several osteopathic hospitals

in Detroit. The publication is distributed weekly by the Comprehensive Health Planning Council of Southeastern Michigan.

The item in question was displayed in a large box and asked for comments on whether the proposed merger should be reviewed on a non-substantive basis. This procedure was entirely inconsistent with the previous handling of similar proposals, including a recent proposed merger of several allopathic hospitals in the east side of Detroit. Project reviews were always handled by a one-line listing showing the applicant's name, the project description and comments.

The proposed merger has the support of the acting president of Michigan State University, the dean of the College of Osteopathic Medicine at Michigan State, the president of Blue Cross Blue Shield of Michigan, the Greater Detroit Area Hospital Council, the Capital Gifts Division of the United Foundation which pledged $2 million in support of the effort, and many other influential groups and individuals.

The certificate of need request is solely for the purposes of merging and seeks no expenditure of capital funds or change in beds or service programs. It is inconceivable that with the support being offered for the project that the local planning agency could determine that the review should be anything other than on a non-substantive basis.

Mergers hold out the best promise of a solution to overbedding, duplication of services, and cost containment in general. The Michigan Osteopathic Hospital Association has long been a proponent of separate consideration for osteopathic facilities and services under the certificate of need laws. To quote from a letter (copy attached) from the President of MOHA to the Executive Director of the planning agency in question:

"Your current action regarding the O.H.D.C. is probably a prime example of just why we have sought this exception."

Previous Federal Efforts

It is most important to note at this point that this Association and the osteopathic profession waged a lengthy and unsuccessful campaign to seek inclusion of appropriate language in the regulations issued by the Department of Health, Education and Welfare to implement the certificate of need program. That effort failed, not because HEW believed our case was invalid, but because the language in Section 1532 (c) of P.L. 93-641 does not provide sufficient flexibility to allow for such consideration in the regulations. In the commentary on the proposal of the osteopathic profession, then Secretary of HEW David Mathews called our concern largely "anticipatory". The examples cited previously in this testimony prove this not to be the case and many of the letters of support for our proposal from Members of Congress add further evidence that the concern is a valid one.

A number of Senators and Representatives wrote to then Assistant Secretary for Health, Theodore Cooper, M.D., in support of our proposal. We believe citations from two of those letters are very pertinent to this discussion. The first is from a letter written by Senator Thomas F. Eagleton (D-Missouri) which said in part:

"It has been brought to my attention that the proposed regulations may, in practice, have the effect of discriminating against osteopathic hospitals. For this reason, I believe that the proposed regulations should be revised along the lines suggested by the American Osteopathic Hospital Association.

"Perhaps more than any other state, Missouri depends upon osteopathic physicians to provide health care to its citizens. We are fortunate to have two fine schools of osteopathy in Kirksville and Kansas City, Missouri, whose graduates often locate within the state. Osteopathic physicians are of particular value in Missouri because most of them are engaged in delivering primary health care and many are located in rural areas that would otherwise be unserved or underserved."

The second citation is from a letter written by Senator William D. Hathaway (D-Maine) to Dr. Cooper:

> "In my state of Maine, for example, osteopaths make up a substantial proportion of the pool of primary practitioners. In many places osteopaths are denied hospital privileges in allopathic hospitals. Given the particular needs of osteopathic physicians, as well as other groups whose service area should be developed separately, I would urge that the final regulations reflect the consideration that must be given to these provider groups and their patients so they may exercise their freedom of choice consistent with the availability of resources and the intent of this Act."

Finally, there were thousands of comments received by HEW from the osteopathic profession and their patients in response to the proposed rules implementing the certificate of need program. A few citations from some of those comments further support our arguments:

> "We believe it to be a constitutional right of Americans to select providers of their choice and that government has an obligation not to legislate against that precious freedom. We can find no substantive argument that makes our appeal an unreasonable one. A growing number of states, including our own, have passed or are considering legislation that does recognize the need to avoid complete monopoly, and we do not see how you can do less.
>
> "Maine is a state that has long struggled to create a medical school as a means of providing primary care physicians to its citizens. The osteopathic profession has realized this need and is well on the way to filling that need by the creation of the New England School of Osteopathic Medicine to be located at Biddeford, Maine, at the campus of St. Francis College.
>
> "It is imperative that the future of this school not be jeopardized by rules that fail to provide for the facilities and services necessary to support such an effort. Similarly, physicians presently in practice must be free to continue providing for their patients in an environment that recognizes their distinctive approach to patient care."
>
> (April 15, 1976, signed by 14 D.O.'s, James A. Taylor Osteopathic Hospital, Bangor, Maine.)

"In summary, the law places all facilities in the same barrel for planning purposes, but Osteopathic (D.O.) and Allopathic (M.D.) hospitals often serve entirely different publics. Thus, there is a good possibility that justified osteopathic needs could be disapproved because of an excess of allopathic facilities in the Community or the reverse situation could also exist.

"As you may be aware, we were able to solve this problem in Ohio by amending the Ohio Sanitary Code by including in the State regulations a sentence or two which allows the planning agency to consider this special problem."

(April 16, 1976, Richard L. Sims, Administrator, Doctors Hospital, Columbus, Ohio.)

"The purpose of this letter is to impress upon you our belief that additional language in these proposed regulations is crucial, in order to protect the rights of osteopathic hospitals, osteopathic physicians and their patients. As you probably are aware, medical staff privileges at other hospitals in Texas are not readily available to osteopathic physicians. Therefore, a substantial number of our population look to osteopathic hospitals to provide the care they need for themselves and their families. It is important to note that allopathic hospitals are not generally accessible to those patients who elect to use osteopathic physicians. As a result, we do not feel it should be left to the discretion of the States whether or not to include separate consideration for osteopathic facilities and services."

(May 3, 1976, Claude G. Rainey, Executive Vice President, Fort Worth Osteopathic Hospital, Fort Worth, Texas.)

"Perhaps your understanding of why I became associated with the Osteopathic Hospital would help you to understand why I believe there should be equal, but separate consideration in the certificate-of-need matter. Over 25 years ago my daughter was deformed from her knees down. My wife and I went to several medical doctors only to hear from each one that the problem could be corrected by fracturing each leg in three places and wearing casts from 6 months up. We finally visited an Osteopathic doctor who told us that it might be necessary to do as the medical doctor had told us, but that treatment could be done anytime until 6 years of age. He would like to try osteopathic treatments first. For the next 6 or 8 months my wife and I did the treatment on the legs exactly as we had been taught. We also bought the built up shoes which he designed and made sure she wore them during the treatment. Anyway, in about two years she had beautifully straight legs and has never had any leg problems since."

(April 28, 1976, H.C. Bevelhymer, Wichita, Kansas.)

CONCLUSION

The American Osteopathic Hospital Association supports sound community health planning; we do not wish to be exempt from the planning law and we are not suggesting a change in the law with regard to the necessity of applying for and receiving a certificate of need. We are not seeking a license to plan in a vacuum, oblivious to the realities which surround us. There is ample evidence that the osteopathic profession and osteopathic hospitals fulfill a vital role in today's health care delivery system and, if allowed to function and plan on the same basis as all other hospitals, unfettered by the restraints of discriminatory and/or politically influenced actions on the part of local and state agencies, the ultimate beneficiary will be the communities we serve.

Therefore, we suggest the following language as an amendment to P.L. 93-641 which would provide for appropriate consideration of osteopathic facilities and services in all applications for certificates of need:

> Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 1532 (c) (3) of Public Law 93-641 is amended by adding the following: "When an application is made for a certificate of need to construct, expand, modernize, acquire capital equipment or add services by an osteopathic or allopathic facility, the need for that construction, expansion, modernization, acquisition of capital equipment, or addition of services shall be considered on the basis of need and availability in the community for services and facilities for osteopathic and allopathic physicians and their patients. The Health Systems Agency and State Agency shall consider the application for a certificate of need in terms of its impact on preserving existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship and residency training levels. Nothing in this criteria shall be construed to dictate a departure from good health planning principles or to mandate unnecessary duplication of services or facilities."

The consumer, the patient, who chooses to seek health care from an osteopathic physician and hospital must be given appropriately equal opportunities under any and all

certificate of need laws and regulations. Osteopathic hospitals and physicians must be allowed to continue to serve their communities as they have for the past 100 years.

The American Osteopathic Hospital Association appreciates the opportunity to testify on this most critical matter and strongly urges this Subcommittee to favorably consider the language we are proposing today. We stand ready to answer any and all questions which you might have. Thank you.

APPENDIX A

CITATIONS OF OSTEOPATHIC CERTIFICATE OF NEED

LANGUAGE CURRENTLY IN FORCE

1. Ohio--HE-8-17 (C) Criteria to be Applied in the Review of Proposals (Effective 1/19/76)----------

2. Florida--Title 27, Section 381.494 (2) Capital Expenditures for Health Care Facilities (1972)----------

3. Rhode Island--Chapter 23-16, Section 12 (1974)----------

4. Oklahoma--Title 63, Article 7 (1975)----------

5. Iowa--House File 354 (Citation not yet available) (1977)----------

6. Michigan-(Now Pending Final Passage), Part 221, Section 22111 (1) (d-e)----------

OHIO

He-8-17 (C) Criteria to be Applied in the Review of Proposals (Effective 1/19/76).

To protect the freedom of patient choice, the needs of the patients of both osteopathic and allopathic physicians shall be considered. In such instances, those facilities and services shall be authorized where there is demonstrated need for osteopathic or allopathic facilities and services.

FLORIDA

Title 27, Section 381.494 (2) Capital Expenditures for Health Care Facilities (1972).

Certificate of need.--When an application is made for a certificate of need to contruct or to expand an osteopathic facility, the need for such facility shall be determined on the basis of the need and availability in the community for osteopathic services and facilities.

RHODE ISLAND

Chapter 23-16, Section 12 (1974).

When an application is made for a certificate of need to construct or to expand an osteopathic facility the need for such facility shall be determined on the need and availability in the community for osteopathic services and facilities.

OKLAHOMA

Title 63, Article 7 (1975).

"Promptly upon receipt of any such application, the Commission shall cause a thorough investigation to be made of the need of the proposed services. The investigation shall include..."
(c) the availability of both allopathic and osteopathic facilities and services to protect the freedom of patient choice in the locality..."

IOWA

House File 354 (Citation Not Yet Available) (1977).

Sec. 4. CRITERIA FOR EVALUATION OF APPLICATIONS.
1. In determining whether a certificate of need shall be issued, the department and council shall consider the following:
j. The appropriate and nondiscriminatory utilization of existing and available health care providers. Where both allopathic and osteopathic institutional health services exist, each application shall be considered in light of the availability and utilization of both allopathic and osteopathic facilities and services in order to protect the freedom of choice of consumers and health care providers.

MICHIGAN

(Now Pending Final Passage) Part 221, Section 22111 (1) (d-e).

A certificate of need program shall be established and shall:

(d) When an application is made for a certificate of need to construct or expand an osteopathic or allopathic facility, consider the need for that facility on the basis of the need and availability in the community for services and facilities for osteopathic and allopathic physicians and their patients.

(e) Consider in terms of its impact on existing and proposed institutional training programs for doctors of medicine and osteopathy at the student, internship, and residency training level the application for a certificate of need.

(2) This section shall not be construed to dictate a departure from good health planning principles or to mandate unnecessary duplication of services or facilities.

APPENDIX B

DOCUMENTATION OF SPECIFIC CASES OF DISCRIMINATION AGAINST OSTEOPATHIC HOSPITALS AND PHYSICIANS

1. Michigan--Monday Comments from CHPC----------
2. Michigan--Flint Osteopathic Hospital----------
3. Ohio--Sandusky Memorial Osteopathic Hospital----------
4. Michigan--Art Centre Hospital----------
5. Colorado--Lee Clinic----------
6. Michigan--The Grand Rapids Osteopathic Hospital----------

Monday Comments from CHPC

Designed to bridge the communications gap, Monday Comments from the Comprehensive Health Planning Council of Southeastern Michigan will bring you up to date on what is happening and about to happen in health planning activities. Mailed each Friday, we hope it will reach you each Monday.

November 28, 1977

MICHIGAN LUNG ASSOCIATION HAS NEW LEADER

On November 1st Robert G. Smith assumed his duties as executive director of the Michigan Lung Association headquartered in Lansing, succeeding Andrew W. Kovacs who held the position for four years. Mr. Smith had previously directed the District of Columbia Lung Association for nine years. In the course of his career he has held various professional positions with lung associations in New York, Florida and North Carolina. Currently he serves as president of the Congress of Lung Association Staff, a national organization of association employees.

REGIONAL MEETING ON CARE OF CANCER PATIENTS

"Hospice and Continuing Care At Home" is the title of a regional meeting being held by the Association of Community Cancer Centers December 1 and 2 at the Detroit Plaza. Topics for discussion at concurrent workshops will be the alternatives in continuing cancer care: hospital, community, and free standing. Included in the two day program will be talks on future prospects for community cancer centers, third party reimbursement, and issues in hospice and continuing care at home.

AHPA CALLS GUIDELINES APPROPRIATE

In testimony before DHEW, the American Health Planning Association described the national health planning guidelines on cost containment as appropriate in the context of a regionally based planning process, viewing them as a starting place from which planning agencies can begin to control the amounts of service required. Warning that further development and clarification of the guidelines are necessary, the Association requested that the process of making exceptions both above and below the numbers specified be carefully delineated. Because of the thousands of letters coming in on the controversial guidelines, DHEW may extend the comment period to the end of the year.

At other DHEW hearings, testimony on open heart surgery, radiation therapy and CT scanning was given. A position paper on the Association's views may be obtained from Elliot Stern, AHPA director of government relations, 2560 Huntington Ave., Alexandria, VA 22305.

GREAT LAKES WATER PROBLEMS SUMMARIZED

Water problems in the Great Lakes region and what people can do about them is the subject of a recent publication of the Great Lakes Basin Commission. Titled Citizen's Summary, the 40-page booklet examines the quality of water in the Lakes, local water supply and sewage problems as well as issues such as erosion and flooding. Possible solutions to problems in each of the five Great Lakes basins are recommended in the summary. For single free copies contact: Public Information Office, GLBC, PO Box 999, Ann Arbor, MI 48106.

RESEARCH ON DRUGS TO CONTROL DEPRESSION

A major research program to determine drugs needed to control serious depression and mania was begun recently by the National Insitute of Mental Health. Grants totalling over a half million dollars have been awarded to five research centers in St. Paul, Indianapolis, Pittsburgh, New York and Albany to test treatment techniques using the drugs lithium and imipramine. It is estimated that more than 80 percent of the 20,000 suicides recorded each year in the U.S. are caused by manic-depressive disorders.

MEETING DATES

Mon.	Nov. 28	1:30 p.m.	Oakland Cty. SAAC Membership	Oakland Cty. Hlth. Dept. Library, 1200 N. Telegraph, Pontiac
Tues.	Nov. 29.	7:30 p.m.	St. Clair Cty. SAAC Annual Mtg.	Port Huron YMCA, Club Rm. A, 700 Fort St., Port Huron
Wed.	Nov. 30	9:30 a.m.	SHCC Exec. Comm.	University Club, East Lansing
Wed.	Nov. 30	1:30 p.m.	Plan Implementation Committee AGENDA INCLUDES ACTION ON: Livingston Care Center, Mercy-Memorial Hospital, Emerald Manor Nursing Home, Huron View Lodge	Howard Johnson, New Center Detroit
Thurs.	Dec. 1	7:30 p.m.	Washtenaw Cty. CHPC General Membership	Washtenaw Comm. College, 4800 E. Huron River Dr., Lecture Hall 3, Exact Science Bldg., Ann Arbor
Wed.	Dec. 7	12:45 p.m.	Administrative Services Comm.	CHPC-SEM Conference Rm., 1200 Book Bldg., Detroit
Wed.	Dec. 7	4:30 p.m.	Detroit City SAAC Gen. Mbrshp.	CANCELLED
Wed.	Dec. 7	7:30 p.m.	Macomb Cty. SAAC Gen. Mbrshp.	Warren Woods Admin. Service Ctr., 27100 Schoenherr, (North of 11 Mile Rd.), Warren
Thurs.	Dec. 8	8:00 a.m.	CHPC-SEM Executive Committee	TO BE ANNOUNCED.

All CHPC-SEM meetings are open to the public; if you desire agenda please call 964-6950.

PROJECT REVIEW

CHPC-SEM has been asked to review the proposed merger of Art Center, Detroit Osteopathic, and Zieger Hospitals on a non-substantive (i.e., staff) basis. Normally, procedures require that staff concur with such a request prior to publication in Monday Comments. In this case the request is still being evaluated and we are taking this opportunity to solicit comments regarding the type of review, (i.e., substantive or non-substantive) on or before December 2, 1977. At that time CHPC-SEM will evaluate any such comments and make a final determination. In the event that CHPC-SEM elects to conduct a non-substantive review no further notifications will be included in this publication.

Applications are available for examination at CHPC-SEM office. Agency policy requires a request in writing and a charge for copies. Interested parties are invited to submit written or oral comments regarding listed non-substantive projects within ten (10) days of date of publication. If no comments are received, or if it is determined the comments do not demonstrate need for full review, the non-substantive review will be carried out immediately after the ten day period. CONTACT: Paula Kelly, CHPC-SEM, 1200 Book Building, Detroit, 48226, 964-6950.

MOHA MICHIGAN OSTEOPATHIC HOSPITAL ASSOCIATION
800 Auburn Rd., Pontiac, Michigan 48057 (313) 335-9716

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Past President
Robert F. Miller

December 20, 1977

Terence E. Carroll, Executive Director
Comprehensive Health Planning Council
Southeastern Michigan
1300 Book Building
Detroit, Michigan 48226

Dear Mr. Carroll:

The Michigan Osteopathic Hospital Association views with alarm the unorthodox handling of the Certificate of Need request filed by the Osteopathic Hospital Development Corporation of Detroit.

Many editions of your publication MONDAY COMMENTS FROM CHPC were scrutinized and it was noted that project reviews were always listed on one line showing the applicant's name, the project description and comments. It seems purposefully inconsistent to have listed in your November 28, 1977 edition, in an outlined box measuring 1 1/2" x 10 1/2" what appears to be an invitation for comments. In that posting, you discuss your 'normal' procedure but present no rationale for treating this request any differently. Inconsistent also, is the treatment you afforded the East Side Detroit Merger which involved a group of allopathic hospitals and that accorded the Osteopathic Hospital Development Corporation of Detroit.

This association has long been aware of the diligent efforts of the hospital organizations participating in the O.H.D.C. We are aware also of the widespread support this effort has received both in the community and statewide. The project has been endorsed by the acting president of Michigan State University; the Dean of the College of Osteopathic Medicine at Michigan State University; the Board and officers of Michigan Association of Osteopathic Physicians and Surgeons; the president of Blue Cross Blue Shield of Michigan; the president of the Economic Growth Council of Detroit; the Greater Detroit Area Hospital

Council; the Michigan Health Maintenance Organization Plans, Inc.; and the Capital Gifts Division of the United Foundation which has pledged $2,000,000 in support of this effort.

It is inconceivable that with this kind of support, and considering the fact that this Certificate of Need request is solely for the purposes of merging and seeks no expenditure of capital funds or change in beds or service programs, that CHPC-SEM could determine that the review should be anything other than on a non-substantive basis. It is simply bewildering that with general agreement that mergers hold out the best promise of a solution to overbedding, duplication of services, and cost containment in general, and with both state and federal legislation now pending which would encourage mergers; that CHPC-SEM would do anything to hamper, discourage, or delay these efforts in its planning area.

The Michigan Osteopathic Hospital Association has long been a proponent of separate consideration for osteopathic facilities and services under the certificate of need laws. Your current action regarding the O.H.D.C. is probably a prime example of just why we have sought this exception.

At the December 8th meeting of our association, a resolution deploring your discriminatory action towards the osteopathic hospitals was passed unanimously. It is hoped that you and/or your board will soon take whatever steps are necessary to rectify this regrettable situation.

Sincerely,

James M. Dwyer

James M. Dwyer
President

JMD/js

cc: CHPC-SEM Board & Executive Committee Members
MAOP&S Board Members
MOHA Board Members
Richard A. Reihmer
Andrew D. Hunt, M.D.
Gerson I. Cooper
George A. Rogers
Maurice S. Reizen, M.D.
Hermann Ziel, M.D.
Jay G. Endsley
E. A. Schuhardt
James P. Lane
Robert S. Wildish

COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN

1200 BOOK BUILDING
DETROIT, MICHIGAN 48226
Phone 313 / 964-6950

January 3, 1978

James M. Dwyer, President
Michigan Osteopathic Hospital
Association
900 Auburn Road
Pontiac, MI 48057

Dear Mr. Dwyer:

Thank you for your letter of December 20, 1977 regarding the application for a Certificate of Need by the Osteopathic Hospitals Development Corporation of Detroit.

I assure you that the processing of that particular application by CHPC-SEM has been entirely consistent with the policies and practices of the organization and I further assure you that the entire review by this organization will be conducted in a fair and equitable manner.

The reason for the format of the announcement of the pending review of the application in Monday Comments was simply to draw attention to the item in order to assure that any comments to be received would be made on a prompt basis.

The merger proposal of the East Side Detroit Hospitals was processed on a non-substantive basis because it met all of the criteria for a non-substantive review. At the time of my decision to review that proposal on a non-substantive basis I had not received a single objection from any organization or person to the proposed merger, nor have I to this date. As you will note from the enclosed material, that has not been the case with the merger proposal we have received from the Osteopathic Hospitals Development Corporation of Detroit. It is certainly apparent to me from the information presented that some significant groups in the community consider the proposal to be a controversial one and moreover may indeed present legal problems.

I am well aware of the supporting statements which have been made on behalf of the proposed merger by significant organizations and individuals. I am also aware of at least some of the sound reasons for approving the proposal. However, it is essential that this organization scrupulously observe due process in the course of its project reviews and that is what I intend to do.

Finally, I feel I must comment on the nomenclature used in your letter. As I have frequently publicly stated, I can find no basis in either federal or state statutes for distinguishing hospitals as either "allopathic" or "osteopathic." Some hospitals are staffed predominately by physicians with degrees and licensure as Doctors of Medicine; others are staffed predominately by physicians who have degrees and licensures as Doctors of Osteopathy. The physician staffing pattern does not, and should not, characterize a hospital as being either "allopathic" or osteopathic." It is the position of this organization, and one which I have personally advocated for many years, that medical staff privileges should not be based on race, religion, creed, national origin, type of medical licensure or any other factor extraneous to the ability of physicians to provide appropriate services to patients.

Sincerely yours,

Terence E. Carroll

Terence E. Carroll
Executive Director

TEC:ss
Enclosures

cc Richard A. Reihmer
Andrew Hunt, M.D.
Gerson I. Cooper
George A. Rogers
Maurice S. Reizen, M.D.
Hermann Ziel, M.D.
Jay Endsley
E. A. Schuhardt
James P. Lane
Robert Wildish
Raymond X. Zweig
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CHPC-SEM Executive Committee

W. DALE FERGUSON
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Flint Osteopathic Hospital

A NONPROFIT CORPORATION / 3921 Beecher Road / Flint, Michigan 48502 / Phone 762-4000

January 17, 1978

C. Robert Benedict
Director
American Osteopathic Hospital Association
603 Pennsylvania Ave. S.E.
Washington, D.C. 20003

Dear Bob:

Approximately two years ago Flint Osteopathic Hospital submitted a letter of intent for certificate of need to install a CT Brain Scanner. I will illustrate for you a very significant problem that osteopathic hospitals have when it comes to certificate of need. That problem is directly and indirectly, the local HSA's and the allopathic community create very high standards when an osteopathic hospital is involved.

In the instance of our application for the CT Scanner entirely new criteria were developed and demanded by FOH. All of these were met, yet repeatedly throughout the process we were attacked, harrassed, and abused as an osteopathic hospital and profession whether we were qualified to have access to a CT Scanner. FOH went through a process of three public hearings.

1. The first hearing, the allopathic physicians and hospital claimed there was no need whatsoever for a CT Scanner.

2. The second hearing, they indicated there was a need for a CT Scanner but not in an osteopathic hospital.

3. The third hearing, the allopathic community indicated there should be a CT Scanner in every hospital including the osteopathic hospital.

4. The recommendation of the HSA staff was the first CT Scanner not be in an osteopathic hospital, even though eighty percent of the scans would be done on an outpatient basis.

5. No recognition was given to the osteopathic physician who was qualified to interpret the CT Scans. The health facility committee of the local HSA recommended that FOH get the scanner. The Board of Trustees of HSA agreed that FOH

receive the scanner. The application and endorsement then went to the State Department of Public Health. FOH was repeatedly pressured to delay the certificate of need process so that other hospital projects could be considered at the same time. We refused to step out of the guideline boundries of the certificate of need deadlines. We finally receive our certificate of need after undue delay and harassment.

The verbal abuse that the profession and the hospital received in the community was tremendous. This was done at public hearings and in many different directions. Our trustees were repeatedly attacked at social gatherings and by other means. The profession was attacked repeatedly by the allopathic community. This still occurs today in many social settings in which I, trustees and fellow osteopathic physicians are criticized because FOH has a CT Scanner.

Since operational the CT Scanner has done a tremendous service for the community but never has anyone given us recognition for this service.

It is obvious that when an osteopathic hospital requests certificate of need, never is the unique role its service to the community ever recognized and accepted by the allopathic community. We receive a tremendous amount of lip service in a private manner, but never publicly.

I am more convinced than ever, that the osteopathic hospitals need a separate certificate of need. Here in our community, Flint Osteopathic Hospital runs 91% occupancy. We are a 401-bed hospital. We deliver more babies than any other institution in the city. We estimate our growth is 50 osteopathic physicians added to our medical staff in the next three to five years. With this projected increase, we need additional acute care beds. Yet we are well aware that when we do proceed through the certificate of need process, we will be severely hampered because the allopathic community will attack the osteopathic profession. The allopathic profession does not understand and want to accept the distinct mode of practice and market penetration that the osteopathic profession has made in community in which they servce.

FOH is the only hospital in this community that has had any significant increase in its service base in the last ten years. Our potential for the future is as great as it has been for the last ten. Yet we will be hampered, harrassed, and abused. FOH will definitely have ten times harder time proving our case because we are an osteopathic hospital. Not because we provide better care and service, but strictly because we are an osteopathic hospital.

I once heard a leading allopathic physician in this town, say that we try harder but what he failed to recognize is that we also are more successful and the community has responded to this acceptance of the profession. Yet, when it becomes evident of our needs, we have to withstand tremendous direct and indirect pressures to stay within limited boundaries. This is completely against the will of the people and only serves the allopathic profession.

Very truly yours,

Dale Ferguson

W. Dale Ferguson,
President
WDF:bc

Sandusky Memorial Hospital
An Osteopathic Institution

2020 Hayes Avenue Sandusky, Ohio 44870 Phone (419) 626-2342

September 8, 1976

Michael F. Doody, President
American Osteopathic Hospital Association
1211 Connecticut Avenue, N. W.
Suite 212
Washington, D. C. 20036

Dear Mr. Doody:

Enclosed is a copy of a newsletter published by the "b" agency in our area during the time we were applying for our expansion program.

Several months after this newsletter appeared Dr. Cashman was replaced by Dr. Ackerman as Director of Health. Dr. Ackerman recinded the "Cashman decision" and gave our project total approval. This decision was in turn upheld by HEW.

Also enclosed is my response to the newsletter to the President of the "b" agency.

Our main concern, even now, is the complete lack of recognition of the special needs of Osteopathic Hospitals.

Our Board of Trustees and our Medical Staff are committed to maintaining an Osteopathic Hospital in our community. And as a result of more Osteopathic Physicians joining our staff we find it necessary to expand we feel we should be allowed to expand regardless of the occupancy levels of non-osteopathic hospitals in our community.

Furthermore we find it difficult to believe that our "b" agency will not consider the fact that we are an osteopathic institution.

EXCELLENCE IN HEALTH CARE

I hope that this information helps you and I hope you are able to bring about and end to this kind of discrimination.

I might add that the federal government should consider osteopathic hospitals as an "endangered species" and therefore should do all it can to protect our survival.

Sincerely,

James K. Johnson
Administrator

JKJ:em

Enc-2

Sandusky Memorial Hospital
An Osteopathic Institution

2020 Hayes Avenue Sandusky, Ohio 44870 Phone (419) 626-2342

January 13, 1975

Kenneth B. Krarkoff, D.D.S.
President, Board of Trustees
225 Allen at W. Wayne Street
Maumee, Ohio 43537

Dear Dr. Krakoff:

I have received a copy of the HPANWO newsletter. In particular your letter to Dr. Cashman I find in extremely bad taste. In addition as the Administrator of Sandusky Memorial Hospital and as a member of the Erie County Health Planning Council, I find it offensive.

Throughout the process of gaining approval for our expansion program we have strictly adhered to the guidelines established by Section 1122 of the Social Security Act and as administered by the Designated Planning Agency of the State of Ohio. The HPANWO is a part of this process. The Areawide Facilities and Service Committee, a committee of your Board, after a thorough review approved our expansion program.

The statement you made in your letter to Dr. Cashman, "I will find it very difficult in the future to ask our committees and Board to spend the time and energy needed to complete an exhaustive review which apparently is not considered" is difficult to understand. You feel perfectly free to criticize Dr. Cashman's decision and yet your Board readily overturned the decision of the committee you charged with completing an exhaustive review of our expansion program.

I have no quarrel with the decision of the Board of Trustees of HPANWO to deny approval of our expansion program. However, just as the Board of the HPANWO is the final decision-making authority in Northwest Ohio on projects like ours so is the Designated Planning Agency the final decision-making authority in the State of Ohio. Through its Director, Dr. Cashman, the Designated Planning Agency of the State of Ohio has granted approval for funding our expansion program. At this point

I wonder why "the HPANWO will continue to vigorously oppose this project". It would appear to me that your organization has had input into the decision-making process regarding our expansion program and statements like "concession to political pressure", and "to expose themselves to the pressures and potential retaliations of disgruntled applicants" not only seem out of order but may have legal implications if those statements in any way hinder or damage the ultimate approval of our expansion program.

Several other statements in the article allude to the fact that the HPANWO is not against the expansion of Osteopathic Hospitals or is the HPANWO against the Osteopathic profession. Based on your actions and the article in your organization's newsletter I find this hard to believe. The article in your organization's newsletter states that you recognize the uniqueness of our institution and yet you never considered this uniqueness when your Board denied approval of our project. If your organization's recognition of our uniqueness was adopted nationwide it would not only mean the eventual elimination of Osteopathic Hospitals but the ulitmate elimination of Osteopathic Physicians as we know them today. I am thankful that other states have adopted different policies than the State of Ohio. They have developed "certificate of need legislation " that provides for the expansion of osteopathic hospitals based on the need for individual osteopathic hospitals to expand.

As for the osteopathic physicians joining the staffs of the two medical hospitals in Sandusky, I suggest that first you get the staffs of the two medical hospitals together.

I agree with the statement that one emergency room fully staffed and equipped would be superior to three. In a similar fashion it would appear that two or three strategically placed emergency rooms in the Toledo area would be superior to nine.

However, if your rationale for this suggestion is the reduction of health care costs in Sandusky you are mistaken. The hospitals in Sandusky unlike larger metropolitan hospitals do not have interns and residents. The saliant point being that even if there were one emergency room in the Sandusky area Sandusky Memorial Hospital, out of concern for the health and well-being of its patients, would still maintain twenty-four hour physician coverage.

In conclusion I would agree that this is not the time for planning by pressure groups although the HPANWO is fast taking on the appearance of one. I further agree that it is the time for statesmenship and in that light I will be happy to meet with you and other representatives of the HPANWO to discuss the future of the health care delivery system for the City of Sandusky and the surrounding communities.

Sincerely,

James K. Johnson
Administrator

JKJ:em

cc: Casper Weinberger, Secretary, Department of Health, Education & Welfare
Eugene Rubel, Director, Comprehensive Health Planning Service, Department of HEW
E. Frank Ellis, M.D., Regional Director, Region V -- Department of HEW
Frederick Robbins, Chairman, Ohio Health Planning Advisory Council
George L. Mylander
John Wasylik, O.D.
Sam Long

Casper Weinberger, Secretary
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John Wasylik, O.D.
540 Buchanan Street
Sandusky, Ohio 44870

Sam Long
Health Planning Association of Northwest Ohio
225 Allen at W. Wayne Street
Maumee, Ohio 43537

Sandusky Memorial Hospital -- Denied Approval By HPANWO -- Granted Approval For Funding By Dr. John Cashman -- Secretary of HEW Is Next

The Board of Trustees of the Health Planning Association of Northwest Ohio (HPANWO), on October 24, 1974, by a 15-5 vote, recommended that the proposed project of Sandusky Memorial Hospital to add 24 medical-surgical beds, be disapproved.

Dr. Kenneth Krakoff, President of the Board of Trustees, stated that the disapproval was not intended as an attack on Sandusky Memorial Hospital or on Sandusky, Ohio. It was taken because Sandusky, Ohio is presently badly over-bedded, with a supply of unused acute care beds existing at Providence and Good Samaritan Hospitals. No capital expenditure is required to use these facilities, just a cooperative spirit. The decision by the HPANWO's Board was to bring about further local consideration of the problem and to encourage sharing of facilities and services, as well as, promote better utilization of these already built and available services.

People who are concerned about the rising costs of health care must realize that the solution to these problems are often in our own back yards. People of Erie County do not have to look far to determine some of these factors in rising health care costs.

The HPANWO is not taking a position which is to be regarded as attacking the osteopathic medical profession or hospital. We recognize that many persons have exhibited a choice for care by osteopathic physicians, and we believe this care is of the highest quality. It is our opinion that this care, can and should, where the situation indicates, be provided in any hospital in the community, as it is in other areas of Ohio and the Nation. The HPANWO realizes that Sandusky Memorial Hospital is in need of modernization and has supported that component of the plan.

The Ohio Department of Health, itself, has said that there is a surplus of hospital beds in the County now. HPANWO's investigation has revealed that osteopathic physicians may apply for hospital privileges at Good Samaritan Hospital. A letter is on file at the HPANWO office to that effect. All general hospital facilities ought to be available to osteopathic physicians and the atmosphere ought to be one in which they feel comfortable.

The future of the matter appears to be that osteopaths and M.D.'s, and to some extent, the hospital, would rather fight than switch. The HPANWO does not feel that such an attitude is mature, reasonable, nor in the best interests of the health of the people of Erie County and the Sandusky area. In the event agreement cannot be achieved, it is the responsibility of the community to resolve this issue of what to do with the overlapping of beds.

On October 25, 1974, Dr. John Cashman issued the following letter to Mr. G. L. Mylander, President of Sandusky Memorial Hospital Corporation:

November 25, 1974

Mr. George L. Mylander, President
Sandusky Memorial Hospital Corporation
2020 Hayes Avenue
Sandusky, Ohio 44870

Dear Mr. Mylander: In Re: ODH File No. A4-0924-B

As Director of the Designated Planning Agency authorized by the Secretary of the United States Department of Health, Education and Welfare to carry out the provisions of Section 1122 of the Social Security Act, I wish to hereby advise you that the proposed capital expenditure referenced below has been reviewed in accordance with our procedures and found to be not in conformity with "criteria, standards and plans developed pursuant to the Public Health Service Act" (Regulations, Section 100.104 (a) (2)).

In submitting this finding to the Secretary, however, I shall recommend that he not exclude reimbursement for capital expenses under Titles XVIII, XIX and V on the grounds that Sandusky Memorial Hospital has "demonstrated proof of capability to provide comprehensive health care services efficiently, effectively and economically, and that exclusion would discourage the operation of the facility" (Regulations, Section 100.104 (b) (2)).

Name of Facility: Sandusky Memorial Hospital

Type of Project: Expansion and Modernization

Estimated Cost: $4,510,000

Although the above finding is in concert with the findings of the Board of Trustees of the Health Planning Association of Northwest Ohio, the recommendation that capital expenses be included in determining reimbursement under Federal programs is a DPA decision not reflective of the Board's intent.

The combined negative finding and positive recommendation is a result of our intention to clearly indicate the DPA's determination to support both the applicable planning documents and the planning process while at the same time recognizing the severe spatial problems at Sandusky Memorial Hospital and the fact that several unique factors are operating in the community which seem to preclude implementation of optimal planning criteria at this time.

Please observe that the DPA does not expect this decision to serve as the impetus for the continued isolated planning by area hospitals. Instead, it is hoped that the events of the past several months have visibly illustrated that community wide planning is a necessity if health care services are to be provided in an atmosphere that promotes quality yet fosters cost

Inasmuch as Section 100.106(c) of the Regulations provides the applicant with an opportunity for a fair hearing in the case of an adverse finding or recommendation, I wish to advise you that a request for an appeal of the decision to the Public Health Council must be received by the Director within thirty (30) days of your receipt of this letter. The details of the fair hearing process can be found in the Project Sponsor Guideline Manual forwarded to you earlier.

Please be advised that I have charged my staff and the Health Planning Association of Northwest Ohio to follow in the future the degree to which the joint responsibility of areawide planning and coordination of services and facilities is being achieved.

Should you have any questions, please note that the files of the DPA are now open for your inspection. If you have any questions, feel free to call or write.

Very truly yours,

John W. Cashman, M.D.
Director of Health

cc: E. Frank Ellis, M.D.
Regional Health Administrator
Region V
Public Health Service
300 South Wacker Drive
Chicago, Illinois 60606
Health Planning Association of Northwest Ohio
Maumee, Ohio 43537

In response to the letter, Dr. Kenneth Krakoff, President of the Board of Trustees of the HPANWO, wrote the following letter to Dr. John Cashman:

December 5, 1974

John Cashman, M.D., Director
Ohio Department of Health
P.O. Box 118
Columbus, Ohio 43216

Dear Doctor Cashman:

I received your communication concerning the application of Sandusky Memorial Hospital under Paragraph 1122 of P.L. 92-603 with surprise, incomprehension and considerable personal resentment.

It has been my understanding and that of the other volunteers and staff of the Health Planning Association of Northwest Ohio that there were very explicit requirements, both under this law and policies of the Department of Health, Education and Welfare, concerning comprehensive health planning, about the maintenance of high standards of health care and effective cost control measures. Consistent with this understanding, the people of this agency have undertaken several very exhaustive reviews and have taken and maintained some positions which were, at best, unpleasant and, in some cases, damaging to personal and business relationships. Those of us who have been involved in these endeavors, have accepted this as part of the price that must be paid in order to accomplish the planning for health to which we have all been committed.

The position which we took in this instance was arrived at after a series of very complete and difficult hearings. The denial of this application, as I hope you are aware, was based upon the conviction that if the community of Sandusky felt that Sandusky Memorial Hospital needed the additional beds it was incumbent upon that community to decide and plan for consolidation of services and/or closure of beds that are not being utilized in the other area hospitals so as to represent no net increase in bed capacity in the area. The remodeling of the hospital was not an issue; and as a matter of fact, it was suggested to the hospital that they might submit another application that encompassed the remodeling without the additional beds.

It is obvious that your position of not approving the application, but of not denying reimbursement, is de facto approval of the project. This being the case, you have not only denied support to this agency, but have very effectively subverted the entire thrust and meaning of comprehensive health planning. Had this situation arisen in an area that had not been labeled by the Insurance Commissioner of Ohio, in agreement with our data, as the most over-bedded county in the State, there might conceivably be some justification for it. But in the present circumstance, I can conceive of no valid reason for this act other than a concession to political pressure. The merits of this particular case were very clear under the requirements of the law; Department of Health, Education and Welfare and Ohio regulations; and, indeed, common sense.

I will find it very difficult in the future to ask our committees and Board to spend the time and energy needed to complete an exhaustive review which apparently is not considered; and in the event of a negative finding, to expose themselves to the pressures and potential retaliations of disgruntled applicants.

In conclusion, I will take the opportunity to remind you that while you have had the signed contract from our agency for many weeks, we have so far not received a signed contract from your agency and will further remind you that to date we have not received funding called for under P.L. 92-603.

Our next Board of Trustees meeting is scheduled for Thursday, December 19, 1974 at 6:30 p.m. at the Stony Ridge Holiday Inn, Exit 5 of the Turnpike. I will recommend to the Board at that time that we stop doing 92-603 reviews until the contract and funding are received and a firm understanding is arrived at between our Board and the DPA as to the effectiveness of our reviews.

Very truly yours,

Kenneth B. Krakoff, D.D.S.
President, Board of Trustees

KBK/jml
c/c: Casper Weinberger, Secretary, Department of Health, Education & Welfare
Eugene Rubel, Director, Comprehensive Health Planning Service, Department of HEW
E. Frank Ellis, M.D., Regional Director, Region V — Department of HEW
Kenneth DeStoetler, Insurance Commissioner, State of Ohio
Governor John Gilligan
Presidents of Board of Trustees of "B" Agencies in Ohio
Frederick Robbins, Chairman, Ohio Health Planning Advisory Council

This is the story of disagreement and conflict. It is viewed by some as Northwest Ohio versus Sandusky Memorial Hospital or Toledo versus Sandusky. The facts are clear that this decision would permit Sandusky Memorial Hospital to proceed, if supported by the Secretary of HEW and by Dr. Cashman.

The HPANWO will continue to vigorously oppose this project, because it feels that the community of Sandusky, its leaders and citizens, doctors and patients, should recognize the need to work together in a cooperative spirit and for better health care and control of health care costs.

The HPANWO has never stated that we wish to prevent Sandusky Memorial Hospital from expansion, since we do recognize their needs as a unique institution serving people of Northwest Ohio. We do, however, state that some use of or adjusted use of existing services and facilities should be made before additional hospital beds are constructed in the community. The HPANWO does support the need for modernization and upgrading of the Sandusky Memorial Hospital's ancillary service areas.

The HPANWO has not created the policy that we will not permit expansion of osteopathic hospital facilities, nor have we adopted a policy of forceful merger of M.D.'s and D.O.'s. We do feel that all hospitals are provided and paid for by the community and that with increasing expenses in health care, it is our responsibility to encourage a sharing consolidation to promote optimal use of these expensive facilities. Osteopathic hospitals will be approved for expansion and enlargement in the future, depending on the demonstrated need and cooperative efforts shown.

What's the next step as we see it? The HPANWO feels that the three hospitals in Sandusky, with medical staff, Board and civic leadership, should begin immediate discussions on cooperative effort in several areas including emergency medical services. One emergency room fully staffed and equipped would be superior to three. Discussions on obstetrical services and pediatric services should be taking place to determine if a plan of consolidation can be achieved.

Medical staffing should be discussed and a climate of cooperation should exist between M.D.'s and D.O.'s. The HPANWO believes that the leadership exists in the Sandusky area to do just that and we pledge our assistance to that end.

The issue of what to do with remaining unused beds in Sandusky remains a serious one, which should also be cooperatively addressed. This is not the time for planning by pressure groups. It is the time for statesmanship, cooperation, and in the spirit of the season, a little real love.

NOTE: This project is one of the first in Ohio, under P.L. 92-603, which requires the HPANWO's review, the State Health Department's review and the Secretary of HEW's review, for health facility projects costing in excess of $100,000; which changes the number of beds; or substantially changes the services in a hospital. This project was approved by the Erie County Health Planning Council and the Areawide Facilities and Services Committee of the HPANWO. The Board of the HPANWO is the final decision-making authority in Northwest Ohio on such projects, and it recommended disapproval.

This article is presented to inform the readers of the Newsletter concerning this issue. We will be glad to print reactions to this article by persons wishing to comment. All comments must be signed, and we will exercise the right to choose those most representative of various points of view. The HPANWO wishes to make it clear that its policy for a bed moratorium on hospitals in Northwest Ohio is still in effect and will continue, in spite of this decision by Dr. Cashman and/or the Secretary of HEW.

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ART CENTRE HOSPITAL
OSTEOPATHIC
5435 WOODWARD AVENUE · DETROIT, MICHIGAN 48202
831-6660

M. L. PONITZ, D. O.
MEDICAL DIRECTOR

R. S. WILDISH
ADMINISTRATOR

September 3, 1976

Mr. Michael F. Doody, President
American Osteopathic Hospital Association
1211 Connecticut Avenue N.W., Suite 212
Washington, D. C. 20036

Dear Mr. Doody:

This is in response to your Mailgram of September 1, 1976, regarding discrimination against Osteopathic Hospitals in the State Certificate of Need and planning process.

In 1974 Art Centre Hospital filed for a Certificate of Need to replace its original hospital with no increase in beds. This was denied and was appealed to the State Facilities Health Commission. Their hearing officer reversed the State Department of Health's decision and recommended approval. The State Health Facilities Commission then disapproved their own hearing officer's recommendation and Art Centre Hospital was denied. One of the reasons stated for the denial of a Certificate of Need to Art Centre Hospital was that issuance would perpetuate overbedding in an already overbedded area. At that time Art Centre Hospital was the only hospital denied and Certificates of Need had been issued to other hospitals throughout the state in similar overbedded areas.

We are currently in the process of appealing this in the Circuit Court. At that time Art Centre Hospital was the only hospital that had been denied a Certificate of Need. Since this date a Certificate of Need has been issued to a hospital in our own district for renovation. It is impossible for us to determine if Art Centre Hospital's unfortunate decision was an act of discrimination.

Should you have any questions regarding this matter, please do not hesitate to contact me.

Sincerely,

R. S. Wildish

R. S. Wildish
Administrator

RSW
jm

ELMER J. LEE, D.O.
PHYSICIAN & SURGEON
MILES D. LEE, D.O.
PHYSICIAN & SURGEON
VIRGIL L. SHARP, D.O.
PHYSICIAN & SURGEON
C. JOHN NICKLE, D.O.
PHYSICIAN & SURGEON

LEE CLINIC
920 12TH ST.
GREELEY, COLORADO

December 27, 1977

Mr. C. Robert Benedict
American Osteopathic Hospital Association
Washington Office
603 Pennsylvania Avenue SE
Washington, DC 20003

Dear Mr. Benedict:

Mr. Oshinsky has given me your letter of December 5, 1977.

I have taken the liberty to enclose some of the arguments we intend to present to our local HSA regarding the discriminating national health planning guidelines.

As far as personal discrimination is concerned, I was twice turned down by Weld County General Hospital. First for staff privileges and general surgical privileges and on a second application turned down for straight staff privileges. These privileges were asked for after ten years of practice in this community. This action took place about 1972.

During the process of these applications, I met with the application screening committee and Dr. Bernerd Wolach, a local urologist, was so extremely rude that it was even impossible to answer the questions that were asked. His forceful accusations and interuptions made it impossible for any kind of presentation for this committee. It was recommended that I talk to the executive committee of the staff following this meeting.

In an executive committee of the staff, I was informed by Dr. Fred B. Groves, that I could never do general surgery at Weld County General Hospital unless I went to some insitution and took adequate training.

The physicians that have been accepted at Weld County General Hospital have been general practitioners with one exception, an eye, ear, nose and throat man who has only had one year of speciality training and does not desire to do EENT surgery at that hospital. He has been active in assisting other eye surgeons in their surgery.

Briefly my background is as follows:

1. Born and raised in this same community.
2. In highschool, my grades were in the upper 10% of my class and I was involved in athletics where I received an award for the outstanding athlete of the highschool and during my stay was a state champion in wrestling.

3. I was accepted to the University of Michigan and had an athletic scholarship.
4. While attending the University of Michigan, I was number three in the national collegiate wresting championships and received the FIELDING YOST award for combined athletic and academic achievement.
5. After three years of pre-med, I was accepted at the College of Osteopathic Physicians and Surgeons in California where I was in the upper 15% of my class and number two on the senior qualifying finals. I was president of my professional fraturnity, Iota Tau Sigma.
6. I was accepted at the Los Angeles County Osteopathic Hospital for internship, a coveted internship.
7. Following my internship, I was accepted in one of two general surgical residencies available in the state of California.
8. On completion of my residency in general surgery at Long Beach Osteopathic Hospital, I returned to practice in my home-town of Greeley, Colorado.
9. During the eleven years of practice, I was accepted as a member in the American College of Osteopathic Surgeons.
10. Following acceptance in the American College of Osteopathic Surgeons, I successfully passed the boards of general surgery.
11. Following being turned down at Weld County Hospital, Dr. John Grow Sr., an eminent cardiovascular surgeon, head of the Grow Surgical Group (eight cardiovascular surgeons), allowed me to scrub in open heart surgery for one and a half years every Tuesday. He certainly accepts me and speaks well of my work. It is unlikely that a better physician exists in the allopathic profession in the state of Colorado than Dr. Grow.

In conclusion, I apologize for having to list some of the places where I have excelled over the years but it is difficult to establish any kind of discrimination unless you know something about the individual you are discribing. I hope this is helpful and I would be glad to help you in any way that I can.

Sincerely yours,

Miles D. Lee, D.O.

ck

Enclosure

THE
GRAND RAPIDS
OSTEOPATHIC
HOSPITAL
A non-profit community teaching hospital

December 28, 1977

The Honorable Frederic A. Grimm
3278 Roosevelt Road
Apartment T-10
Muskegon, Michigan 49441

Dear Judge Grimm:

Recent action of the West Michigan Health Systems Agency Board with serious potential impact on Grand Rapids Osteopathic Hospital prompts this letter.

It is our understanding that a motion was defeated 14 to 13 on the question of allowing an Osteopathic Hospital obstetrical service to be exempted from the proposed Health Systems Agency goal of 1,500 minimum deliveries per year in population centers of 100,000 or more. A letter from Mr. McCarthy, our President, had drawn your attention to the fact that strict interpretation of that goal could close all but one osteopathic obstetrical service in the entire United States (actually, there are two hospital corporations which could meet this goal; however, only one is a single, unitary institution); this purely on the basis of arbitrary numbers and with no objective analysis of comparative cost or outcomes in terms of successful deliveries of healthy infants from healthy mothers. This also, despite the fact Grand Rapids Osteopathic Hospital has demonstrated mortality, morbidity and length of stay statistics equal to or better than most centers that deliver in excess of 2,000 babies a year. (See Michigan Department of Public Health "Perinatal Mortality By Hospital Birth, Michigan 1970-72" as distributed June 23, 1975.) We are hospital number 133 in this study.

The HSA Board members should be aware of the impact on services to this community should it propose to force closure of the obstetrical unit of Grand Rapids Osteopathic Hospital.

1. Closure of the postdoctoral training program for interns. A rotating internship in an AOA approved osteopathic hospital is required for osteopathic practice licensure in Michigan. An AOA approved program requires obstetrical experience in an osteopathically oriented institution. Our internship program currently is training 14 interns, many of whom will become family practitioners in the West Michigan area. These interns would be deprived of exposure to the treatment of newborn infants as well as the management of obstetrical delivery.

   The only way an intern program could be continued in the absence of obstetrical service at Grand Rapids Osteopathic Hospital would be to send osteopathic interns to another osteopathic hospital which would meet the volume requirements of the HEW Guidelines. The one such osteopathic hospital in the country obviously cannot provide such training programs for the 1,000 D.O. graduates expected in 1978 and in future years.

2. Closure of the Residency training programs in Obstetrics/Gynecology Our four-year residency program in this primary care specialty provides for training of three residents at a time at present. These residents are not only being trained to deliver a needed service, they participate in the teaching of undergraduate medical students, the care of patients in obstetrics and gynecologic surgery and in the operation of a clinic for the medically indigent and high risk women of the area. All obstetricians on our staff at this time are graduates of our program.

3. Closure of the OB/Gyn Clinic which would deprive high risk-mothers of pre-partum, post-partum and gynecology services, as well as a choice of physician and hospital.

4. Closure of educational classes for expectant parents which stress teaching of the physiology of pregnancy, labor and delivery as well as parenting and infant care.

5. Probable disruption of the Hospital's major affiliate status with Michigan State University College of Osteopathic Medicine. All five osteopathic hospitals with major M.S.U. affiliate status in Michigan are required to provide a teaching program for students in eight major medical disciplines including obstetrics. The HEW Guidelines, if strictly applied, would close all but one of the five major teaching hospitals affiliated with the University, creating an impossible student load for the one remaining hospital.

In addition to all of the above, closure of the obstetrics services of Grand Rapids Osteopathic Hospital would waste the many thousands of dollars recently expended to renovate our obstetrical labor, delivery and nursery areas to comply with State requirements. This renovation was done with the approval of the Michigan Department of Public Health and completed in 1976.

Therefore, we are concerned that Mr. McCarthy's letter to WMHSA pointing out one area of national concern from an osteopathic hospital standpoint was simply summarized and not mentioned at the meeting prior to Mr. Leegwater's, a vice president of our hospital, raising this issue. We had hoped our letter would make WMHSA sufficiently aware of the problem to permit opportunity for dialogue, which, unfortunately, never materialized.

We further understand that the proposed amendment ultimately considered by the HSA Board dealt with two completely separate issues, namely: the exemption of osteopathic hospitals from the 1,500 delivery rule and a proposal to permit additional CAT Scanners in the region under certain circumstances. Since these questions were not divided, it would seem difficult to assess what might have been the outcome on either had they been considered separately.

In view of all the above considerations, we would like to ask that the matter of obstetrical delivery numerical requirements be reconsidered, at least as they apply to osteopathic teaching hospitals and in particular to Grand Rapids Osteopathic Hospital.

Given the opportunity, we would be most happy to present further testimony before the WMHSA Board regarding this vital issue.

Very truly yours,

J. Preston Miller, Chairman
Board of Directors
Grand Rapids Osteopathic Hospital

cc: Russell J. Etzel, First Vice President
Ms. Arlene Hoover, Second Vice President
Gerald VanNoord, Secretary
Alvin E. Jacobson, Jr., Treasurer

Robert J. Baker, M.D.
Honorable Leo Bebeau
Owen Dieber
Ms. Sylvia L. Dirckhead
Harold E. Bowman, M.D.
Robert L. Broersma
Ms. Marjorie Byrnes
Ms. Patricia Camp, R.N.
Jesse L. Carter
William J. Chaille
Emeterio A. Cisneros
Ms. Mabel Porteous
David E. Post
Winston B. Prothro, M.D.
D. Lee Satterlee
Donald B. Birtwistle
Russell L. Shepherd
Donald Sheridan
Charles G. Shidler
Ms. Barbara Smith
Leslie V. Spriggs, D.O.
Robert D. Swartz
Melvin A. Tardy
Ms. Lea Tobar
Theodore S. Vanderveen, M.D.
John B. Wilkes, M.D.
Harrison R. Wilson
H. Rhett Pinsky

Douglas E. Jenks
Ms. Joyce Kortman
Richard C. Lague
Michael O. Lareau
Ms. Harriett McBride
Donald McInnis
Ms. Esther Mitchell
Peter H. Iversen
Dennis Nickels
James T. Peek
Ms. Nancy Clair
Ms. Joyce Collins, R.N.
Father Patrick Cawley
Thomas Cooper
Ms. Jessie Dalman
Reverend Terry L. Daly
Wilson C. Deaver
William J. Downer, Jr.
Jerry L. Erickson
James M. Farrell
John Halmond
Ms. Bernadine Hedrick
Honorable Stuart Hoffius
Frank Howell, D.O.S.
Paul E. Inglis
J. Henry Irwin
William Jackson

cc: Philip E. VanHoest, Executive Director
West Michigan Health Systems Agency

bc: Michael Doody, President
AOHA

Mr. MAGUIRE [presiding]. Dr. Adler.

STATEMENT OF PHILIP ADLER, D. O.

Dr. ADLER. My name is Philip Adler, D.O., president of the American Osteopathic Association. With me is Mr. John P. Perrin, who is director of the Washington Office of AOA. We are most pleased to have the opportunity to present our views on the Health Planning and Resources Amendments of 1978.

We have a prepared statement, Mr. Chairman. With your permission, we will have it entered into the record of these proceedings [see p. 630]. It addresses a number of suggested changes in the planning law not included in the planning amendments.

We will restrict our oral testimony to the single issue which we perceive to be of the greatest importance to the osteopathic profession under the health planning process. That issue is need certification for osteopathic services and facilities.

At the time the National Health Planning and Resources Development Act of 1974 was under consideration we were satisfied that the minimum criteria required to be developed in State certificate-of-need programs would surely include an affirmative requirement that the need for the expansion or modification of an osteopathic facility would have to be viewed against the need for and availability of such osteopathic services within the health service area.

In implementing the certificate-of-need provision of the planning law, the Secretary of HEW failed to include this as a specific requirement in the final regulations. In the preamble to those regulations, the Secretary acknowledged the "pervasive concern" for such a provision and stated that "because of his concern about discrimination against populations who wish to be served by osteopathic services and facilities in their communities, strongly encourages State agencies and HSA's to incorporate consideration of the needs of the population being served by such services into their health plans."

We were appreciative of the Secretary's cognizance of the issue and his articulated sensitivity for the needs of populations groups being served by osteopathic services and facilities. However, the failure to require positive assurance that osteopathic facilities' and services' requests for certificates of need will be reviewed in light of osteopathic demand for such services exposes the profession and its patients to the unacceptable risk that local planning bodies may not be as sensitive as the Secretary to insuring access to adequate osteopathic services and facilities by its patients.

Such lack of sensitivity—or outright discrimination—has already manifested itself in a number of instances through the decisions of local HSA's with respect to application for certificate of need by osteopathic facilities. Some of those occurrences have been documented for you by our hospital association in its testimony.

We would also note that we have had indications from several States that the absence of a specific requirement for separate consideration of osteopathic facilities has been construed by State health authorities as prohibiting such a provision in their State program.

This very unfortunate interpretation is currently being advanced in Florida, where the State Department of Health is seeking the removal of the existing separate consideration provision from the State code for "nonconformity with the Federal law and regulations."

Where insensitivity to the needs of our patients exists, it negates the freedom of choice of the patient and fails in the essential objective of the planning law to institute a program of comprehensive and sound health planning, assuring access to quality care at reasonable costs, in response to actual health care requirements.

It is our sincere belief that this objective cannot be accomplished without taking into consideration the present structure of the health care delivery system, which includes osteopathic and allopathic physicians practicing in osteopathic and allopathic institutions in response to patient desire or demand for such services.

The osteopathic profession is a politically and philosophically separate and educationally independent school of medicine. D.O.'s comprise 5 percent of the physician population but care for 10 percent of the population, or about 20 million patients. In order to guarantee the osteopathic patient his right to select the provider of his choice, he must have the choice of treatment facility.

The American Osteopathic Association recognizes and concurs with the philosophy of the certificate-of-need legislation to regulate the growth of hospitals as a means of controlling health care costs. We further agree with the existing criteria applied in making need certification decisions. What we are asking is that such criteria be applied separately to osteopathic facilities and services.

To accomplish that end, we respectfully request that section 1532(c)(3) of Public Law 93–641 be amended to read: "The need that the population served or to be served has for such services, the need to construct, expand or modify an osteopathic facility, shall be determined on the need and availability in the community for osteopathic services and facilities."

The AOA has consistently supported sound health planning programs. Our request for the suggested amendment to the certificate-of-need provision is wholly consistent with the congressional intent of the planning legislation to insure the availability of all necessary quality care. Failure to address this issue can only serve to create new problems in the system of health care delivery.

That concludes our statement. We will be pleased to respond to any questions.

[Dr. Adler's prepared statement follows:]

STATEMENT OF PHILIP ADLER, D.O., PRESIDENT,
AMERICAN OSTEOPATHIC ASSOCIATION

MR. CHAIRMAN, Members of the Subcommittee, my name is Philip Adler, D.O., President of the American Osteopathic Association. With me is Mr. John P. Perrin who is Director of the Washington Office of AOA. We are most pleased to have the opportunity to present our views on the Health Planning and Resources Amendments of 1978.

The American Osteopathic Association has had the privilege of appearing before this subcommittee on many occasions, but never have we come to address an issue of as great importance to the osteopathic profession, its patients and institutions as that which we shall address first in our statement, today. That issue is need certification for osteopathic services and facilities.

At the time the National Health Planning and Resources Development Act of 1974 was under consideration, we were satisfied that the minimum criteria required to be developed in state certificate-of-need programs would surely include an affirmative requirement that the need for the expansion or modification of an osteopathic facility would have to be viewed against the need for and availability of such osteopathic services within the health service area.

In implementing the certificate-of-need provision of the planning law, the Secretary of HEW failed to include this as a specific requirement in the final regulations. In the preamble to those regulations, the Secretary acknowledged the "pervasive concern" for such a provision and stated that "because of his concern about discrimination against populations who wish to be served by osteopathic services and facilities in their communities, strongly encourages state agencies and HSAs to incorporate consideration of the needs of the population being served by such services into their health plans."

We were appreciative of the Secretary's cognizance of the issue, and his articulated sensitivity for the needs of populations groups being served by osteopathic services and facilities. However, the failure to require positive assurance that osteopathic facilities' and services' requests for certificates-of-need will be reviewed in light of

osteopathic demand for such services, exposes the profession and its patients to the unacceptable risk that local planning bodies may not be as sensitive as the Secretary to insuring access to adequate osteopathic services and facilities by its patients.

Such lack of sensitivity (or outright discrimination) has already manifested itself in a number of instances through the decisions of local HSAs with respect to application for certificate-of-need by osteopathic facilities. Some of those occurrences have been documented for you by our hospital association, in their testimony.

We would also note that we have had indications from several states that the absence of a specific requirement for seperate consideration of osteopathic facilities has been construed by state health authorities as prohibiting such a provision in their state program. This very unfortunate interpretation is currently being advanced in Florida, where the State Department of Health is seeking the removal of the existing separate consideration provision, from the state code, for "nonconformity with the federal law and regulations."

Where insensitivity to the needs of our patients exists, it negates the freedom of choice of the patient and fails in the essential objective of the planning law to institute a program of comprehensive and sound health planning, assuring access to quality care at reasonable costs, in response to actual health care requirements.

It is our sincere belief that this objective cannot be accomplished without taking into consideration the present structure of the health care delivery system which includes osteopathic and allopathic physicians practicing in osteopathic and allopathic institutions, in response to patient desire or demand for such services.

The osteopathic profession is a politically and philosophically separate and educationally independent school of medicine. D.O.s comprise 5 percent of the physician population but care for 10 percent of the population or about 20 million patients. In order to guarantee

the osteopathic patient his right to select the provider of his choice, he must have the choice of treatment facility.

The American Osteopathic Association recognizes and concurs with the philosophy of the certificate-of-need legislation to regulate the growth of hospitals as a means of controlling health care costs. We further agree with the existing criteria applied in making need certification decisions. What we are asking is that such criteria be applied separately to osteopathic facilities and services.

To accomplish that end we respectfully request that Section 1532 (c) (3) of PL 93-641 be amended to read "The need that the population served or to be served has for such services; the need to construct, expand or modify an osteopathic facility shall be determined on the need and availability in the community for osteopathic services and facilities."

The AOA has consistently supported sound health planning programs. Our request for the suggested amendment to the certificate-of-need provision is wholly consistent with the congressional intent of the planning legislation to insure the availability of all necessary quality care. Failure to address this issue can only serve to create new problems in the system of health care delivery.

Our remaining concerns, in the planning structure and process, under the law as now written, relate to the composition of the HSA Boards.

In order to insure that health planning decisions are predicated on the best possible information, drawn, at least in part, from the practical medical expertise within the HSA region, we believe that some modification of the provider representation provisions needs to be made.

Specifically, we recommend the following amendments, with respect to provider participation in the health planning process:

1. Amend Section 1503 (b) (1) To require at least one physician representative, selected from active practice, as a member of the National Council.

2. Amend Section 1512 (b) (3) (C) (2) So as to (a) require inclusion of at least one representative from a hospital, or hospitals, located in the area; and (b) require inclusion of at least one physician engaged in active practice in the area.

3. Amend Section 1524 (b) (1) (C) So as to (a) Require that at least three-fourths of provider members be direct providers, and (b) include at least one representative from each of the provider categories enumerated in Sec. 1512 (b) (3) (C) (11).

We believe that the foregoing changes will upgrade the provider input to health planning decisions, without dominating them. We respectfully request that you give them favorable consideration.

We thank you for the opportunity to present our views on these very important issues.

Mr. MAGUIRE. Thank you. Mr. Carter.

Mr. CARTER. I don't want to discriminate against osteopathic physicians. Certainly as one member I want to consider the amendments which you have submitted. Thank you, Mr. Chairman.

Dr. ADLER. Thank you.

Mr. MAGUIRE. Thank you, Mr. Cooper and Dr. Adler.

Our next witness is Dr. Frank Bowyer, president, American Dental Association. You may present your full statement for the record and summarize it if you wish.

STATEMENT OF I. LAWRENCE KERR, D.D.S., MEMBER, BOARD OF TRUSTEES, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY ERIC BISHOP, ASSISTANT EXECUTIVE DIRECTOR FOR DENTAL HEALTH

Dr. KERR. Thank you, Mr. Chairman. I am substituting for Dr. Bowyer, who had a death in his family. I am Dr. I. Lawrence Kerr, of Endicott, N.Y. In addition to maintaining a private dental practice I am a member of the board of trustees of the American Dental Association, which I am representing here today.

I happen to be only one of 130 dentists who are privileged to serve on an HSA board. I happen to serve on an HSA review committee and have for many years served on New York State CON bodies such as the State Hospital Review and Planning Council.

With me is Mr. Eric Bishop, the association's assistant executive director for dental health. We are pleased to have this opportunity to appear before the committee once again.

May I add: I would like to take the opportunity to thank the chairman and Dr. Carter for their great interest in dental health over the many years I have been privileged to watch you both.

Since enactment of the National Health Planning and Resources Development Act, the American Dental Association has done more than merely observe its implementation. We have attempted to participate to the fullest extent possible. Among a number of programs we have undertaken, I would like to mention only three regional conferences which we financed and sponsored in 1977. At the initial conference, we were fortunate enough to have the chairman, Mr. Rogers, present the feature address. We are, of course, equally grateful to Mr. Florio and Mr. Waxman for their participation as well as to Dr. Harry Cain and his staff.

The dental profession, then, has not ignored Public Law 93–641. We have been doing our best to work with this complex law during a trying period of initial organization. This process of organization is far from complete, as the chairman observed in his opening statement.

In this connection one threshold problem that has been most vexing is the restrictiveness of the law with regard to representation of and participation by dentists. We believe strongly that health planning should be open and that every group in the community with expert knowledge and deep interest should be welcomed within the process. Unfortunately this is not presently the case. We think it is wrong and

short-sighted to force the various categories of health professionals and allied health personnel to compete for membership on the Health Systems Agency, the Statewide Health Coordinating Council and the National Planning Council. Each group has unique insights and valuable experience to offer. Certainly the dentists of each community can offer worthwhile assistance with respect to a segment of the health care delivery system that, on a national basis, involves over 100 million patients and $9 billion in expenditures. A guarantee in the law that practicing dentists will have a voice at the local, State and national level is essential. We strongly urge an amendment to this effect.

When we testified on this legislation in 1974 we recognized that well-structured health planning is an important element in improving the availability and quality of health care. We also expressed deep concern, which we still have, over unjustified Federal intervention in health planning and regulation. We opposed placing unduly broad discretionary powers in the hands of the Secretary of HEW permitting him to override or by-pass local and state health planning agencies and units of government. That occurred recently and dramatically when proposed guidelines issued by the Department were withdrawn and modified only after a ground swell of opposition from citizens and Members of Congress. It must be made clear, as stated by the chairman, that decisions about the adequacy of health services will be made at the local level. We hope this committee, by appropriate amendment, will assure that this situation will not recur.

We think it is most important for Congress to require the Department to recognize that planning decisions must be arrived at cooperatively with communities, not imposed by Federal fiat. Federal legislation should have the flexibility to allow local jurisdictions to respond to their own unique problems. We strongly recommend, therefore, that the law be amended to make clear that Federal guidelines may not unilaterally preempt local determination as to the need for health facilities and services.

Related to our concern in this area is the proposal that has been made to add two new national health priorities under section 1502. Our problem is not with the desirability of the goals in themselves but with the manner, based upon the recent experience alluded to earlier, in which the language might be implemented.

Additionally we believe the wording of the two new goals should be carefully considered. It is, we think, the prime purpose of planning to establish a rationale for subsequent actions. Such rationale itself needs to be known, debated and accepted within the community before final decisions are made. In this light, we believe planning purposes would be better served if goal 11 were to read: "Formulate criteria by which existing or potential duplicative or unneeded health services and facilities can be identified and avoided." Goal 12, we would suggest, would better read: "the adoption of policies that demonstrate the cost effectiveness, appropriate use and optimum efficiency of present and future health care delivery systems."

We also note that the proposed amendments would enact changes in certificate-of-need requirements. It is not our intention to comment on certificate of need as it relates to institutions. There is nothing on

the record, however, that would justify its use in relation to the private dental office. We would oppose inclusion of such offices and believe specific exemption for them should be provided in the law.

Another section of H.R. 10460, concerning consumers, is exceptionally welcome. This is section 213(a), which would require each HSA to have an identifiable program of providing assistance to members of its governing body and committees. We believe it most important that all voting members have a minimum level of knowledge and information on which to base judgments. Indeed we believe that all governing body members could well be required to undertake an appropriate amount of education prior to assuming duties. In this regard, we hope that recognition in the law can be given to the resources that private sector organizations such as ours can offer as part of this process. We would hope to have the opportunity to participate in educational assistance by providing materials and reports and being actively involved in training programs.

I work with one of the finest HSA's in the country. I believe its success is due to the fact that we equally participated in the education process, sir.

The right of consumer members to adequate education about the health care system raises the related question of reliable and reasonably uniform data. Both Pub. L. 93–641 and sections of H.R. 10460 require many judgments to be made. Without solid facts at the disposal of HSA's and others, those judgments are too often going to be mere guesses. Too many bad guesses are going to cripple the entire planning effort.

In our view, attention needs to be given to the potential of a cooperative effort in data-gathering by the National Center for Health Statistics, State and local public agencies and health professional associations. A consensus needs to be reached on what is now being done well and what needs improvement. Without this kind of analysis there is no hope of providing HSA's with the full range of reliable information they require.

With this in mind we would suggest that section 201(a)(1) of H.R. 10460 be amended to include a one-time requirement that the Secretary report to Congress on the present health care data base, its strengths and deficiencies, the sources from which data are actually or potentially available, the shared role of the public and private sectors in gathering data and a plan by which necessary data will be made available to those who need it for decisionmaking. We would cooperate fully in such an effort.

In closing, while taking note of the reservations we have about aspects of the existing law, we would want to distinguish those from our commitment to careful and cooperative planning. As the committee reviews the legislation, we are hopeful it will not lose sight of the fact that adequate time must be given for a system to be put into place and become well accepted. All of us, of course, are impatient to see concrete results. But if the health planning process is to truly serve the long-term interests of the public, it must be allowed to mature before we burden it with regulatory duties and demands. The quality of the results we achieve from the system are directly

dependent upon the patience we exercise at the beginning in creating the mechanism. A forced growth will not prove permanently useful.

I might add, Mr. Chairman, I would like to support personally those amendments which would give more financial support to an HSA such as mine. We are doing a big job and we need the help.

Mr. Chairman, I thank you on behalf of the American Dental Association for this opportunity to appear. With your permission, we will be filing additional comments for the record. Mr. Bishop and I will be glad now to respond to any questions.

Mr. ROGERS. Thank you very much, Dr. Kerr, for a very positive and helpful statement——

Dr. KERR. Thank you, sir.

Mr. ROGERS [continuing]. Contrary to some we have had from other organizations. So we commend you. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Certainly I feel you have made an excellent presentation today. I would like to see more dentists on HSA boards. We have two dentists in an HSA group. I would like to see your tribe increase. I think it would be a great help.

The two amendments which you mention here, I think, would improve, as far as I can tell, the language in the bill. Certainly I could go along with them. "Oral surgeons do not require equipment that could exceed $150,000"—I have never taken a position that we should put a cap on those expenditures.

Dr. KERR. Thank you, Dr. Carter. Up to now the highest number in dollars for a piece of equipment that any of us has ever used is almost a spin-off from the CAT-type equipment. I would say no dental office I know would have equipment that would anywhere near meet the $150,000 base.

As one who has participated in the CON for a long time I just don't see where we would help the system by doing that. We are providing a fantastic service to 100 million people a year through this delivery system. We understand the planning. This is why we are participating so vigorously.

Mr. CARTER. Thank you very kindly. I am happy to see you working within the HSA system to improve it. Thank you, Mr. Chairman.

Mr. ROGERS. I am certainly encouraged by your testimony. Your suggestions we certainly will take very seriously. We appreciate your presence here today.

Dr. KERR. You weren't in the room, Mr. Chairman, when I mentioned this, but we want to thank you for your participation in the conferences on this very subject, in which you were of tremendous assistance to us.

Mr. ROGERS. Thank you. We were very pleased to respond to the ADA.

Dr. KERR. Thank you.

Mr. ROGERS. This will conclude the witnesses this morning. We will adjourn until 2 o'clock this afternoon. The committee stands adjourned.

[Whereupon, at 11:45 a.m. the subcommittee recessed, to reconvene at 2 p.m. the same day.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, presiding.]

Mr. ROGERS. The subcommittee will come to order, please. We are continuing our hearing this afternoon on Health Planning and Resources Development Amendments of 1978.

We have a panel now composed of: Consumer Coalition for Health; Mr. Herbert Semmel, Consumer Coalition for Health; Mr. Barry Checkoway, University of Illinois, Department of Urban and Regional Planning; Anne Fenerty, board member, Central N.E. Colorado HSA and Mr. Steve Suitts, Southern Regional Council from Atlanta.

We welcome each of you to the committee. We are pleased to have you here. Each of your statements will be made a part of the record in full, so if you can highlight the statement for us and point out the most important features, that will be helpful to the committee.

You may proceed.

STATEMENTS OF HERBERT SEMMEL, PRESIDENT, CONSUMER COALITION FOR HEALTH; STEVE SUITTS, EXECUTIVE DIRECTOR, SOUTHERN REGIONAL COUNCIL; BARRY CHECKOWAY, ON BEHALF OF CHAMPAIGN COUNTY (ILLINOIS) HEALTH CARE CONSUMERS; AND ANNE FENERTY, ON BEHALF OF CENTRAL NORTHEAST COLORADO HEALTH SYSTEMS AGENCY

Mr. SEMMEL. Thank you, Mr. Chairman and Mr. Carter. We appreciate the opportunity to testify on the amendments to the National Health Planning Act. We want to express on behalf of the Consumer Coalition for Health our appreciation to you, Mr. Rogers, for your encouragement in the formation of the coalition.

We have also submitted in addition to our statements the report of the Southern Regional Council on HSA's in the south and the report of Herbert Hyman, an HEW consultant on HSA's in HEW regional 2 for the committee's consideration, and if the committee desires to make it a part of the complete record [see p. 641].

Chairman ROGERS. Yes; without objection it is so ordered.

Mr. SEMMEL. The fundamental question which we believe faces the Congress in this legislation is the issue of control of the health planning processes. To put the question most simply, is this going to be just another case in which those who are supposed to be regulated end up dominating the regulatory processes?

Are we going to have 205 regional CAB's, ICC's and FCC's? I hope the answer to that question is no, because of many reasons, one of which is that the congressional purpose of achieving cost control through a number of methods including the planning process is just not going to work if the people who are supposed to be controlled are in control themselves.

The notion of planning in health care and cost control will succeed only if there is a broad public constituency in support of that notion. In order to achieve that support, there has to be citizens and citizen

groups that become interested in the processes and support it. In the past there have been a number of cases where citizen groups have become involved in the issues, have organized and have participated effectively, and when given the opportunity have, in fact, exercised what we would consider community control and input into health system agencies at various levels. In Champaign County, Ill., Mr. Checkoway will relate his experience. It has happened in Cape Cod, Savannah, Ga. and Little Rock and a few other places.

The reason why it was able to happen in those cases, but has not occurred in most areas of the country, is that in most cases the so-called "outsiders", that is the public, are frozen out of the process by the fact that the usual means of choosing boards for HSA's is a self-perpetuating mechanism in which the current members reelect themselves and elect their successors.

This problem is compounded because of the method of initial selection of the agency boards. Initially, in many cases the agencies were organized by the groups that have traditionally been dominating the health planning processes under the old health planning legislation which Congress did away with.

These groups were primarily organized medicine and hospitals and other such institutions, so that the end result is that this initial organizing group became the agency and then they self-perpetuate themselves in office. I think Mrs. Fenerty will relate her experience in Denver as one example of the process which goes on all around the country.

Because of that we wholeheartedly support the prohibition on self-perpetuating boards which is found in the legislation now before this committee. In our detailed statement we have suggested some alternate language which would maintain that principle but would also give some flexibility to ensure compliance with the requirements that the board be "broadly representative."

I should like to turn to that issue now, that is, the issue of "broadly representative."

Although Congress clearly spelled out in the law the notion that economic, social, racial, linguistic and geographical groups should be broadly represented on the HSA boards, that did not come about in certain situations in practice. The group most consistently grossly underrepresented is the entire half of the population with incomes below the median, which is approximately $15,000 family income.

The studies which we have given you demonstrate conclusively that low and moderate income people just have not received anywhere close to the representation they should be receiving. For reasons which we spell out, by and large HEW has done nothing about this situation.

This has lead to a number of law suits. The first law suit was successful at the District Court level in obtaining an order that low and moderate income people should be represented in roughly approximate proportions to their percentage of the population. At that point, when the case was on appeal, HEW promised the United States Court of Appeals in New Orleans that they would promulgate regulations on the subject.

The court, therefore, issued a decision which said in effect that "broadly representative" meant what HEW interprets it to mean. But HEW has never issued those regulations. Accordingly, we have suggested a change in language which would not change any substance, but would simply make clear the intention of Congress.

A third point which I would like to call to the committee's attention and which is not included in the bill, is the requirement for membership on subcommittees and advisory boards. In practice, most of the crucial decisions are made in the subcommittees and advisory boards because the number of decisions which come before the full HSA board or even the executive board are so great that most of the work has to be done effectively in the subcommittees and advisory boards.

The act now says that subcommittees and advisory boards should meet the representational requirement to the extent practicable. That has been largely ignored in practice. We have case after case in which the advisory boards and subcommittees tend to have either all or predominantly all providers in these groups and no effort is made to include consumers.

So we have suggested that the act be clarified to require a consumer majority on the subcommittees and advisory boards. We are not suggesting that these boards meet all the representational requirements because that is too difficult in some of these very small committees, but there is no reason why there should not be a consumer majority on these boards.

Another thing which is touched on in the legislation but which we feel needs considerable strengthening is the provision of both training and technical assistance for not only HSA board members, but for all of those who are included in this process on subcommittees and advisory committees and subarea councils.

We feel that the consumer members are experts on the kinds of needs and the reality of the provision of health care in the areas in which they live, but there is an enormous amount of technical assistance they need in translating that into plans, into evaluations of the variety of applications that come before an HSA board.

I think if you took the stack of testimony which has been presented to this committee and piled it up, you would get an idea of the height and weight of matters that come before HSA's at any particular meeting.

On the question of certificate-of-need, we have made some detailed comments in our written statement. I would particularly like to urge the committee to enact a provision which would exempt health maintenance organizations from the certificate-of-need requirement except for new hospital construction. We feel that it is the policy of the Federal Government and that it is cost effective to encourage HMO's.

In reality the politics of getting approval of HMO's certificate-of-need or approval for federal funding varies from area to area. We feel that at least for a period of years an exemption from the certificate of need would be very beneficial to the development of these organizations.

I would like to pass the microphone to Mr. Suitts.

[Testimony resumes on p. 675.]

[Mr. Semmel's prepared statement and attachments follow:]

STATEMENT BY

HERBERT SEMMEL

ON BEHALF OF THE

CONSUMER COALITION FOR HEALTH

ON H.R. 10460

HEALTH PLANNING AND RESOURCES DEVELOPMENT
AMENDMENTS OF 1978

BEFORE THE

HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

FEBRUARY 1, 1978

The Consumer Coalition for Health* appreciates this opportunity to testify concerning the provisions of H.R. 10460, the Health Planning and Resources Development Amendments of 1978. There are a number of important provisions in this bill which are essential to a health planning process which can help achieve quality care and equitable distribution of services at reasonable cost. At the same time, we must note that there are some provisions in this bill which would work against that purpose and there are also some important omissions.

The question of control of the health planning process is the most fundamental decision facing Congress

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*/ Herbert Semmel is President of the Consumer Coalition for Health and Director of the Center for Law and Social Policy, a public interest law firm in Washington, D.C. The Consumer Coalition for Health was formed in September 1977 following a conference in Washington in June 1977 on the role of consumers in health planning. The purpose of the Coalition is to achieve better health care through effective planning. The June conference was attended by a broad spectrum of persons from around the country: professional health planners, community health activists, trade union officials and members, public officials, and representatives of other consumer groups. The consensus of the meeting was that health planning held out the promise of moving the country forward to the goal of equitable access to health care, quality care and reasonable cost. However, the planning process is not achieving these goals because the health planning process is still dominated in practice by the medical establishment predominantly organized medicine, hospitals and other institutions.

in this proposed legislation to extend the health planning laws. Is the health planning process going to end up as just another case in which those interests which are supposed to be regulated actually control the regulators? Are the HSAs going to become small regional versions of the Civil Aeronautics Board, traditionally dominated by the airline industry; of the Interstate Commerce Commission, traditionally dominated by the transportation industry; or the Federal Communications Commission, traditionally dominated by the broadcasters? Or will Congress reaffirm its goal of citizen control of the decisions which affect their health and lives? The answer to these questions will be the best indicator of whether Congress is serious about controlling the inflationary spiral in health care costs.

In the area of health planning, Congress has a unique opportunity to avoid the unusual control of the planning and regulation process by industry. In fact, Congress clearly intended when it passed The National Health Planning and Resources Development Act of 1974 to avoid just such a result. For the first time in history, Congress required that a basic planning agency, the health systems agency, not only be made up of a majority of consumers, but that this majority be broadly representative of the social, economic, linguistic and racial population of the area. But the promise of the legislation has been frustrated by the ability of the medical establishment and their allies to maintain control of HSAs

in most areas of the country, and by the failure of HEW to take any action to correct this. This failure on the part of HEW began in the Ford Administration and has continued into the Carter Administration. HEW has designated, and continues to re-designate, HSAs which have self-selected and self-perpetuating governing bodies, completely unaccountable to the public or to anyone else other than to themselves. HEW continues to designate HSAs although there is demonstrable, clearcut evidence which shows that the mass of the population, the low and moderate income families, are grossly underrepresented on HSA Boards, which are dominnated by persons with high incomes who constitute only a small percentage of the total population. The evidence also shows clearly that women, in most cases, are substantially underrepresented on HSA boards.

These facts are well known to HEW. As early as May 1976 HEW received a report by its own consultant, Herbert Hyman, who found gross underrepresentation of low income people in every one of the HSAs he studied in HEW Region 2. Subsequently, in 1977, the Southern Regional Council presented results of a detailed study of HSAs in the South which once again documented the gross underrepresentation of the mass of the population in HSAs. These reports are part of the supplemental materials which the Consumer Coalition for Health has submitted today to this Committee.

HEW's refusal to face up to this issue is highlighted by a third report on the membership of HSA governing bodies which HEW commissioned for hundreds of thousands of dollars

to the Okrand Corporation. Although the report runs to hundreds of pages, and a massive amount of information is collected, at no place does the report ever analyze the incomes of HSA consumer members. However, the report did go into the occupational groups represented among the consumer members. It found 65% of the consumer board members were classified in professional and managerial positions, 10% in the remaining occupational categories and 22% were in the civilian labor force. For executive committees, the figures for these categories were 75%, 7% and 17% respectively. The report noted, "In contrast, Census data indicates that 13% of the population is in the professional and managerial occupation, and 22% were not in the civilian labor force. Thus, the higher-status occupational groups were extremely overrepresented while persons of lower-status occupational groups and not in the civilian labor force were extremely underrepresented. This underrepresentation was even greater for the Executive Committee."

The Orkand Report also noted that women constituted 33% and 29% of the consumer members of the governing boards and executive committees respectively, which concluded that women were underrepresented on the HSA boards and even more so on the executive committees.

Furthermore, HEW has failed to promulgate any regulation defining the term "broadly representative" or defining permissible methods of selection of HSA governing bodies.

The frustration which the average person faces when trying to become involved in activities of HSAs is best exemplified by the situation in the HSA for North Central Texas, headquartered in Dallas and known as Texas Area 5 HSA. The process of the development of this agency, as documented by sworn depositions of the officials of the HSA taken in connection with litigation, shows that the HSA was developed out of a political compromise between the group supporting the then existing regional health planning agency and other groups, prinicpally one organized by doctors and hospitals in the rural areas of the HSA district. When the HSA held public hearings, as required in its development process, a group of concerned citizens, organized in Texas ACORN, a neighborhood based group, attended the hearing and urged that the governing body of the proposed HSA be opened up to people of all income levels. Despite the fact that they attended every one of the meetings, despite the fact that they had a personal meeting with the regional health administrator of HEW in Dallas, the resulting board of directors of 41 consumer members contained only 3 persons with incomes at or below the median for the area, which was $10,000. 33 of the 41 consumer members of the board of directors had annual family incomes of more than $15,000 and 20 had annual family income above $25,000. Thus with no other recourse, Texas ACORN went to court, where it was initially successful in the U.S. District Court in obtaining an order requiring the HSA to comply with the broadly representative

requirement of the law if it wished to continue receiving federal funding. Rather than acknowledge that the HSA was out of compliance, HEW appealed this case to the U.S. Court of Appeals for the 5th Circuit. On that appeal, they urged the Court not to interfere with the designation process but rather to leave the matter to HEW's discretion. As part of that argument, they promised the Court of Appeals that they would issue regulations defining "broadly representative." In their brief submitted to the Court on June 8, 1977, HEW stated:

> "The Secretary has now concluded that 'more specific regulations' both of the composition of the HSA governing bodies and the methods of selection of members is imperative; and the federal defendants represent to this Court that the process of developing such regulations has already begun within the Department."

Subsequently, HEW sent another letter to the Court promising the publication of proposed regulations in the Federal Register. In November of 1977, HEW sent a letter to Senator Kennedy promising that these regulations would be published by December 1, 1977. No such regulations have ever been published. In fact, in its submission to the House Subcommittee on Health and the Environment on January 30, 1978, HEW did not even list regulations on HSA governing boards as a subject which was in the process of being developed.

Because of this position taken by HEW, the United States Court of Appeals for the 5th Circuit did defer to HEW's discretion in this matter. It is therefore essential that the Congress reaffirm in this legislation now before this Committee the requirement that HSAs shall be broadly representative of the population and shall not continue to be dominated by the medical establishment.

The Consumer Coalition for Health supports the position set forth in the proposed bill before this Committee which would ban self-perpetuating governing bodies on HSAs. The democratic principle of accountability to the public must prevail. At present, self-perpetuating boards are the most common method in which HSA boards are selected and re-selected.

We suggest that the objective of the Congress could be achieved with legislative language slightly differing from that which appears in the proposed bill. The Consumer Coalition for Health recommends the following language on the issue of accountability to the public and banning self-perpetuating governing bodies. "Consumer members of the governing body of the agency shall be selected in a manner (approved by the Secretary) which provides for accountability to the population of the Health Service Area served by the agency, subdivision-thereof, or the population groups represented on the governing body, and not more than one-third of the total consumer members may be elected or othewise selected by the governing body itself, or portion thereof. Providers shall not participate

in the selection of consumer members." Such a revision would give full flexibility to each HSA to determine the details of the method of selection, so long as the principle of accountability to the public is preserved. A number of HSAs already respect the principle of public accountability. Some hold elections at large in the entire district. Others hold elections for members of the sub-area councils and those persons who are democratically elected choose delegates to the HSA governing boards. Other HSAs may choose to have governing body members selected by a variety of community organizations representing the diverse social, economic, linguistic and racial groups in the population. Other HSAs may choose a combination of these methods or other methods consistent with accountability to the public.

We have included in our proposal language which would allow the consumer members of an HSA governing body to choose up to one-third of the total consumer members selected. The purpose of this provision is to allow the HSAs some flexibility if needed to meet the broadly representative requirement of the statute. In some cases, the result of the selection process may not satisfy the representation requirement, and the Board would then be authorized to add additional members so that if a particular race, economic class or social group were underrepresented, the matter could be adjusted. This process allows a reconciliation of a democratically accountable selection process with the result-oriented broad representation requirement.

The proposed language also would prohibit providers from participating in the selection of consumer members. There have been several cases which have documented the interference by providers with the selection of consumer HSA board members. This occurred in Pennsylvania, Arkansas, and California among others. The usual pattern of this type of interference appears to arise when large institutional providers bus their employees to the polling areas when HSA board members are being selected, and instruct their employees on which members to vote for. All these employees are providers within the meaning of the statute. The purpose of the law providing for a consumer majority is totally frustrated when provider groups can handpick the consumers on HSA boards.

The second essential requirement for an effective planning process independent of the providers and major institutions representing them is the Congressional command that HSAs be broadly representative of the social, economic, linguistic racial and geographic population. Unfortunately, as a result of the decision by the U.S. Court of Appeals for the 5th Circuit in Texas ACORN v. Texas Area 5 HSA , the words "broadly representative" in the statute have been rendered largely meaningless. The Court said in effect that the words mean whatever HEW interprets them to mean. But HEW has not interpreted them, and as noted above, has broken its promise to issue regulations on the subject. The failure of HEW to

give guidance on this issue has led many HSAs to ignore the requirement of broad representation. Furthermore, as documents obtained in discovery in pending litigation over the issue reveal, the regional health administrators have complained to HEW in Washington about their inability to enforce the requirements because of lack of adequate definition, but have still not received necessary advice. This has led many regional health administrators to simply ignore the issue, particularly in the area of economic and social groups of the populations. In Texas Area 5, for example, the regional health administrator designated the HSA in the face of strong protest by Texas ACORN and documentation that only 3 out of 41 consumer members of the Board of Directors have annual family incomes at or below the median for the area. There is also no evidence whatsoever on the record at HEW to show that any person with higher income represented the lower income group. In testimony in connection with similar litigation in New Orleans, the regional health administrator testified that he simply relied on the HSA to meet the broadly representative requirement.

The result of all this, as shown by the report mentioned above (3-4), is that there are enormous disparities and gross underrepresentation of low-income families and of women. In the supplemental materials submitted to the Committee, we have included the official HEW form entitled "Consumer Membership Profile" for the Mid-Atlantic HSA headquartered in Baton Rouge. That form shows that only

one person among the 16 consumer board members has income under $10,000 and only one has income under $15,000. Thus, 14 out of 16 consumers had incomes over $15,000 but represent well under half of the economic and social population of the area. The form also shows that of the 16 consumer members, 15 are male. The pattern of Louisiana is repeated throughout the country. In many cases, HEW has approved HSAs without any information as to the economic status of the members of the Board. For example, we have included in the supplemental materials a biographical form used by the statewide HSA in Delaware, which was recently designated by HEW. There is no information on income on this form, so HEW could not have known whether the requirement of broad representation for economic and social classes has been met.

Because of the cloud which the Texas ACORN decision has placed on the expression "broadly representative" it should be changed in the statute to make the intention of Congress clear. We recommend the following language be inserted in Section 1512(b)(3)(C)(i) by inserting after the word "providers of health care" the following:

> "...who approximate the economic, linguistic racial, sexual and elderly population, geographic areas of the health service area, and major purchasers of health care (including labor organizations)."

Essentially, this language substitutes the word "approximate" for the words "broadly representative of." The words "social" which is contained in the current provision has been omitted because it is too vague. We have added in its place two

major population elements not currently recognized explicitly in the statute, that is, sex and the elderly. The section should also provide that each HSA have at least one representative of the handicapped on its governing body and sub-area council. It should also provide that when there are a substantial number of persons in the population with specialized health problems, such persons should be represented on the HSA boards, for example, textile workers in North and South Carolina who have special problems with brown lung disease, coal miners with black lung disease, and similar situations.

The proposed language also includes labor unions in the definition of "major purchasers of health care." We are pleased to note that such a revision has also been included in the bills introduced in both the House and the Senate. In many areas, labor unions are major purchasers of health care but indirectly through the collective bargaining process. An amendment to the statute should recognize this status of labor unions and unions should be granted representation on all HSAs as major purchasers of health care except in the small number of areas where no substantial portion of the population are union members.

Division of Governing Bodies Among Consumers, Providers and Public Officials.

Current law states that there must be a majority of consumers on HSA governing bodies. The Okrand Report found that consumers constituted almost 53% of HSA board members although it also found 12 HSAs that had provider majorities.

Even where there is a consumer majority, Undersecretary Champion stated on January 30, 1978, before the Subcommittee on Health and the Enviornment of the House that "such a balance can sometimes be more theoretical than real, and we are concerned about the effects on the health planning process in such cases."

The Consumer Coalition for Health urges that in order to protect the concept of consumer majority health planning decisionmaking, the HSA governing boards be required by law to constitute 60% consumers, 25% providers and 15% public officials. Experience has shown that at HSA board meetings, there is often a provider majority. The reason for this is that although there are one or two more consumers on the board, provider representatives have better attendance records because their membership on the board is part of their professional life. Most consumer represetnatives are serving in their spare time as a public service so that cosumer attendance is understandably lower than provider attendance on the average.

The second problem is the status of public officials on HSA boards. Because of the fact most governmental entitites operate health facilities of varying kinds, there is substantial confusion in practice over whether public officials serving on HSA boards are providers or consumers. In most cases, they have been considered consumers unless they are directly involved with the operation of health services, such as the head of the Department of Health.

If the health facilities involved are in the private sector, it is quite clear that most public officials would be at least indirect providers because of their relationship to the health facility. The best way to handle this problem is to have a separate portion of the board which is neither consumer nor provider , and is designated public official, and which may be either eleected public officials or appointed public officials or persons designated by elected public officials.

The Consumer Coalition for Health is pleased to note Undersecretary Champion's statement on January 30 that HEW intends to offer a provision in its proposed bill for separate representation for [illegible] public officials, while retaining a consumer majority ,. As Mr. Champion stated, under the HEW proposal, "the current requirement that a majority of the board members be consumers be retained, and elected officials and their representatives may not also be counted as consumers for the purpose of meeting the requirement of consumer majority." However, we believe that the HEW proposal to require that 25% of the HSA board be locally elected officials is too high and a figure of 15% would be more appropriate.

Subcommittees and Advisory Boards

In practice, many of the crucial decisions made by HSAs are actually made in the Subcommittees and Advisory Boards. The mass of decisions which face

an HSA often do not permit the Board members to fully explore the issue and the recommendations which come to them from the various subcommittees and advisory boards often become the decision of the HSA without substantial modification.

In practice, providers tend to dominate the subcommittee and advisory boards both in members and in influence. An employee of an HSA in New Jersey reported to us that of 7 advisory groups and subcommittees, five had no consumers on them whatsoever and two others had provider majorities. This is an extreme case of a prevailing practice of large provider majorities on subcommittees and advisory boards.

The Consumer Coalition for Health urges that subcommittees and advisory boards be required to have a majority of consumers and that the other representational requirements be met to the extent practicable as in current law. The smaller size of advisory groups and subcommittees may make it impossible to meet the full representation requirements, but there is no reason why consumer majorities should not be required.

Effective Participation by Governing Bodies and Committee Members

Consumers are in fact experts on the health care needs of their communities and the failures and deficiencies in the current health care systems in their areas. Most consumers, however, lack the technical expertise, training, and education to translate their understanding of needs into more formalized

decisions and plans. Some providers, on the other hand, have a combination of professional status and technical training and expertise to dominate the decisionmaking even where there are independent consumer participants in the process. To put it bluntly, without independent technical assistance, consumers are often buried under a mountain of figures and reports which they lack the time to analyze or are snowed by professional jargon. This problem can be approached and consumers made more effective participants in the health planning process if consumers have both adequate training and technial assistance.

There should be a requirement that all members of HSA governing bodies and subordinate bodies complete an orientation or training program of not less than 10 hours within 3 months after appointment or selection to the body. The training program should not be run by the HSA staff, but by separate entities.

In addition to training, independent technical assistance must be provided to consumer participants at all levels of the planning process to insure their ability to function effectively and independently. HSA board members and persons on subcommittees and advisory boards are often faced with massive amounts of material which they are expected to understand and evaluate. This includes certificate of need applications, applications for federal funding as well

as health service plans and annual implementation plans. Consumers need independent technical assistance in order to analyze these papers. This technical assistance must be independent of the HSA staff in order to avoid conflict of interest. The function of the consumer advisor in many respects is to critique the work of the staff of the HSA. There are many cases in which HSA staff may have substantial differences, but these differences disappear in final staff reports and the staff coalesces around its recommendations.

Accordingly, independent technical assistance should be mandated, one consumer advisor for each HSA, with HEW having authority to require greater numbers as needed by either large populations or geography. This technical assistance could be provided by the regional technical assistance centers or by other community non-profit organizations, and funded by HEW.

Certificate of Need

The provision for state certificate of need programs lies at the heart of the ability of health planning to insure equitable distribution of resources and development of sound cost containment policies.

We know of only one state, Arkansas, which meets the current regulation for certificate of need. Experience indicates that by 1981 when the current statute requires full compliance by all states, many will not be in compliance.

What will happen then is that the pressure for further extension will be irresistable because of the plea of the states that they suddenly lose so much funding and would have to substantially curtail their health programs. For example, North Carolina, in its unsuccessful challenge to the constitutionality of Health Planning Act, claimed that just under 50% of all non-Medicare and non-Medicaid health funding in the state would be lost if it failed to comply with the certificate of need requirement. We have recently seen the same kind of problem in which Congress has twice extended the deadline for states to comply with the utilization review requirement for long-term care facilities under Medicaid.

Accordingly, we support the principle of phased reduction in funding under the Public Health Service Act and other laws if the state does not satisfy the certificate of need requirement.

Consumer Coalition for Health believes that the current domination of health planning by the medical establishment can be used and has been used in some places, to stifle the development of health maintenance organizations. HMOs are encouraged by federal law and in many situations have demonstrated their ability to provide quality, comprehensive health care at substantially lower cost than the fee-for-service basis. This movement must not be stifled.

The Consumer Coalition for Health therefore urges that closed-panel HMOs should be excluded from certificate of need requirements except in new hospital construction. New hospital construction certificate of need requirements should be subject to a final decision by the Secretary of HEW in the case of closed-panel federally qualified HMOs. The experience in Washington, D.C. where the Group Health Association, one of the oldest and best established HMOs, has been unable to obtain its own hospital facility, demonstrates the need for federal review of state decisions denying certificate of need applications by HMOs for hospital construction.

Additional Comments

We have attached to our testimony the complete set of legislative proposals and amendments to P.L. 93-641, developed by the Consumer Coalition for Health, and specific statutory language with respect to Section 1512(b)(3)(C). In addition, comments on other important provisions of the House bill follow by section number:

Section 206(c)(1)(B)(ii) and Section 208 - We oppose any authority which would permit HSAs to accept funds from foundations which receive substantial contributions from providers as defined in the Act. The most likely foundations to fund HSAs will be those which are the creations of the corporate health care industry. Such funding would seriously threaten the independence of the HSA. Furthermore, to protect the independence of the HSA, a limit on the portion of the total budget of the HSA which came from private sources should be set.

Section 209(b) is unnecessary. It adds an additional category of direct providers who are already well represented by practicing health care professionals and direct institutional providers.

Section 209(d) eliminates the twelve month waiting period before ex-indirect providers can serve on HSAs as consumers. The provision will serve to perpetuate provider dominance by allowing an easy switch from provider to so-called consumer, and it should be deleted.

Section 211(b) - The proposal to have a minimum size for executive committees is beneficial, but ten is too small a number, since it means only six consumer members, hardly likely to represent a cross section of the governing body. In practice, in many HSAs the Executive Committee is the true governing body.

Section 213(b) - The allowance of advances for expenses of attending meetings is important to assure participation by the average income consumer.

Section 215 - We support the requirement of staff expertise in preventive and public health matters.

Section 216(c) - This section is not desirable as it shifts planning power away from the agencies responsible to the population, the HSAs and SHCCs and concentrates more power in the bureaucracies of state planning agencies. In particular, the section appears to mandate that the Health Service Plan, the basic planning document, be excessively influence by top-down planning since it must conform to the determination of the state agency as to statewide health needs. Similarly, section 217(c), although apparently designed to increase efficiency, will also increase the domination of the state agency.

Section 218 - We support the requirement that certificate of need approvals be reviewed annually to measure progress.

Section 218 - The new section 1527(a)(5) is unfairly loaded in favor of institutional providers seeking certificate of need approval. It should be amended to include a right of appeal for the public and for HSAs if certificate of need is granted over their objection.

Section 219 - This appears to require states to close down facilities. The subject requires much greater consideration than given by the committee, including issues of compensation for employees and affected institutions and protection of the interest of consumers. The subject should be dealt with in separate legislation.

Consumer Coalition for Health
"Consumers United for Better Health Care through Effective Planning"

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January 10, 1978

PROPOSALS FOR AMENDMENTS TO P.L. 93-641

A. Composition of Health Systems Agencies Governing and Supporting Bodies.

In the long run, the planning act will achieve its objectives of equitable distribution of health care resources, quality care, and cost containment only if HSAs are controlled by independent consumer majorities accountable to the public they represent and the groups they represent. This is not the case at present. Most HSAs are not accountable and are not representative of the population, particularly with regard to economic groups and sex. Most HSAs were organized by the physicians and hospital administrators who have traditionally dominated the health planning process and the entire health care system. In some cases, local or state officials also played a role in the organization of HSAs. The first governing bodies of HSAs and sub-area councils were selected by these organizing interests. The general pattern of HSA by-laws is to provide that the current board reelects itself and elects its successor. Of course this is not universal and there are a number of HSAs which have much more accountable systems. On the whole, however, the pattern is self-initiated, self-perpetuating HSA governing boards.

1. Broadly representative HSA boards As a result of the decision by the United States Court of Appeals for the Fifth Circuit in Texas Acorn v. Texas Area Five HSA, the words "broadly representative" have been rendered largely meaningless. Therefore, to make the intention of Congress clear, the "broadly representative" clause of subsection (i) should be changed to read as follows:

> "(i) A majority...who are consumers of health care...and who approximate the economic, linguistic, racial, sexual, and elderly populations, geographic areas of the health service area, and the major purchasers of health care."

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COSSMHO—National Coalition of Hispanic Health Organizations and Human Service Organizations
National Consumers League
National Council of Senior Citizens
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United Auto Workers

The word "social" which is contained in the current provision has been omitted because it is too vague. We have added in its place two major population elements not currently recognized in the statute, that is, sex and the elderly. The section should also provide that each HSA have at least one representative of the handicapped on its governing body and SACs. It should also provide that where there are a substantial number of persons in the population having specialized health problems, such persons should be represented on the HSA boards, for example, textile workers in North Carolina and South Carolina who have special problems with brown lung disease, coal miners facing black lung disease, and similar situations.

2. Percentage of consumers and others on HSA boards. There are two major problems with the current formula for division of HSA boards between consumers and providers. Although the statute allows up to 60% consumers, an HEW survey has shown that in practice consumers represent only 51% of HSA boards. As a result, at actual HSA board meetings, there is most often a provider majority. The reason for this is that provider representatives are on the boards as part of their professional life, whereas most consumer representatives are serving in their spare time as a public service. Consumer attendance is understandably lower than provider attendance on the average.

The second problem is the status of public officials on HSA boards. Because of the fact that most governmental entities operate health facilities of varying kinds, there is substantial confusion in practice over whether public officials serving on HSA boards are providers or consumers. In most cases they have been considered consumers, unless they are directly in charge of the operation of health services, such as the head of the Department of Health. If the health facilities involved were in the private sector, it is quite clear that most public officials would be at least indirect providers because of their relationship to a health facility. The best way to handle this problem is to have a separate portion of the board which is neither consumer nor provider, but is designated public official, and who may either be elected public officials or appointed public officials.

Accordingly, the formula for HSA boards should be 60% consumers, 25% providers, and 15% public officials.

3. Non-professional health workers.

Non-professional health workers are completely exclud from the provider representational categories. There should be a change to require that at least one representative of non-professional health workers be included in the provider category. In many cases, it is the non-professional health

worker who has the most regular contact with patients, and who may be in a better position than anyone else to provide input on the quality of care and the areas where services are inadequate.

4. Method of selection. There should be a specific provision that the method of selection of consumer representatives must provide accountability to the public at large or to the groups which individuals represent. Because of diversity in organization of HSAs, it is probably not feasible to prescribe a particular method of selection, so long as the accountability is adhered to. It would be better to allow HEW administrative discretion to enforce this provision, so long as self-perpetuating boards are prohibited. It is also important that there be a provision prohibiting both direct and indirect providers from voting on consumer representation. At present, such voting is a major technique for continuance of provider domination. On most self-perpetuating HSA boards, new consumer representatives are elected by combined vote of consumer and provider representatives. Since there is usually only one more consumer than providers on a board, it is very simple for the providers to band together and dominate the election of consumer representatives. Similarly, in some areas where consumer representatives are chosen through an election process, provider institutions have organized large numbers of their workers and brought them to the polling places. Since the number of persons participating in these elections tends to be a small percentage of the population--only those most concerned about health care at the present--block voting by several hundred hospital employees can determine the outcome of an election. All of these institutional employees are indirect providers.

5. Labor union representation. The present law recognized "major purchasers of health care" as entitled to representation on HSA boards. In many areas, labor unions are major purchasers of health care, but indirectly through the collective bargaining process. As a result, neither HEW nor most HSAs have recognized labor unions officially as major purchasers of health care. An amendment is required to carry this out, and labor unions as well as management should be granted representation on all HSAs as major purchasers of health care except in the small number of areas where no substantial portion of the population are union members.

6. Subcommittees and advisory boards. The Act now requires that subcommittees and advisory boards need to meet the representational requirements only "to the extent practicable." Although it may be difficult for all committees to meet all representational requirements, because of small size, there is no reason not to require consumer majorities. In practice, committee reports often become decisions of the larger bodies. The current loophole has resulted in provider-

dominated committees. In one area, East Central Illinois HSA, the SACs were reconstituted as area advisory committees because they lacked consumer majorities as a way of getting around compliance with the requirements for representation on SACs.

7. Non-metropolitan representatives. This provision should be clarified so that it specifically requires that non-metropolitan representatives include persons actually living in rural settings. In many situations, the non-metropolitan representatives come from the urban centers in the rural areas and are not truly representative of the interest of the rural population.

B. Certificate of Need.

Although certificate of need can be utilized, and in many cases is being utilized, by the already established provider institutions to perpetuate themselves and prevent innovation, on the whole it appears that certificate of need is necessary for effective planning and cost containment. A number of changes are needed to make the certificate of need program effective and a major exception must be included to prevent stifling of the creation of HMOs.

1. Exclusion of HMOs. To facilitate the development of closed panel HMOs, they should all be excluded from certificate of need requirements except for new hospital construction. This exclusion should apply to both federally qualified and non-qualified closed panel HMOs. This is necessary because some HMOs cannot meet federal qualifications at first, but can do so after a reasonable start-up time.

2. HMO hospital construction. HMOs should be subject to state certificate of need requirements on hospital construction except that for closed panel federally-qualified HMOs, the decision of the state agency should be subject to review and reversal by HEW.

3. Coverage of certificate of need. The required coverage under the current regulations is inadequate and should by statute be expanded to include doctors' offices, CAT scanners (wherever located), home health agencies, and leasing and new acquisitions.

4. Federal facilities. Federal facilities should be subject to certificate of need requirements, except that the decision of the state agency would only be advisory and HEW would have final certificate of need authority over federal facilities.

5. Consumer majority on state agencies. The final decision on certificate of need by a state agency should be made by a panel which contains a majority of consumers appointed for fixed terms.

6. Compliance with plans and guidelines. If an HSA or a state agency makes a certificate of need decision which is not in compliance with the applicable health service plan, state health plan, state medical facilities plan, or the national planning guidelines, the agency should be required to state in writing the reason for not adhering to the applicable plan.

7. Judicial review. If state law permits judicial review of final certificate of need decisions, then the HSA in the area and any person or entity which participates in the certificate of need review, including by testimony at a hearing, should be required to have standing for such an appeal. Similarly, all such persons should have the right to participate in any administrative appeals.

8. Progress towards certificate of need compliance. To date, only one state, Arkansas, meets the current regulations for certificate of need. Experience indicates that by 1981, when the current statute requires full compliance by all states, many will not be in compliance. What will happen then, is that the pressure for further extension will be irresistible because of the plea of the states that they will suddenly lose so much funding and would have to substantially curtail their health programs. For example, North Carolina in its lawsuit challenging the constitutionality of the Planning Act, claimed that just under 50% of all of its non-Medicare-Medicaid health funding in the state would be lost if it failed to comply with the Planning Act. We have recently seen the same kind of problem in which Congress has twice extended the deadline for states to comply with the utilization review requirement for long-term care facilities under Medicaid.

What is therefore needed is a system of incentives and penalties which are appropriate to the dimension of the issue and which will result in compliance by the state. As an incentive, Congress should appropriate funds already authorized so that HSAs would have monies to grant for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the health system plan. However, these funds should be available only in those states in which HEW makes a determination that the state is making substantial progress towards full compliance with certificate of need requirements and will meet

all of those requirements within the time period specified in section 1521(d). On the penalty side, there should be a reduction in funding for state agencies not making substantial progress towards full compliance with certificate of need. The reduction should be on an accelerating scale, beginning, for example, July 1979 with a reduction of 25%, moving to 40% by January 1980, and 50% by July 1980.

C. Effective Participation by Governing Body and Committee Members

Consumers are in fact experts on the health care needs of their community and the failures and deficiencies in the current health care systems in their areas. Most consumers, however, lack the technical expertise, training, and education to translate their understanding of needs into more formalized decisions and plans. Providers, on the other hand, have a combination of professional status and technical training and expertise to dominate the decision-making even where there are independent consumer participants in the process. To put it bluntly, without independent technical assistance, consumers are buried under a mountain of figures and reports which they lack the time to analyze or are snowed by professional jargon. This problem can be approached and consumers made into more effective participants in the health planning process if consumers have both adequate training and technical assistance.

1. Technical assistance. Independent technical assistance must be provided to consumer participants at all levels of the planning process. One consumer advisor should be mandated for each HSA with HEW having authority to require greater numbers where needed by either large population or geography. The consumer advisor should be completely independent from the staff of the HSA or other body so as to avoid conflict of interest. The function of the consumer advisors in many respects is to critique the work of the staff of the HSA. These technical assistants could be employed by the regional technical assistance programs now in effect, or by other community non-profit organizations, and funded by HEW.

2. Training HSA participants. There should be a requirement that all members of HSA governing bodies and subordinate bodies complete an orientation or training program of not less than 10 hours within 3 months after appointment or selection to the body. The training program should not be run by the HSA staff,
but by separate entities as described above.

3. Availability of PSRO data. Current law gives HEW complete discretion on regulations to make data collected by PSROs public. HEW has not as yet promulgated any regulations and the result is that all PSRO data remains secret. This data is essential to the planning process. Indeed, there is no way that an HSA with its limited staff and resources can obtain the kind of information which is available under the profiles of individual and institutional providers which are prepared by PSROs. If the data is to be available to the planning agencies, it must also be available to the public. Otherwise the result would be secret decision-making. In addition, much of the information would be of great value to the public. Therefore, all PSRO data, except that which identifies individual patients, should be available to all planning agencies and the public. As protection against erroneous interpretation of the data by the public, the committee reports should clearly indicate that the data should be released with an explanatory statement designed to reduce any possible misunderstanding.

Consumer Coalition
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January 10, 1978

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

Proposed Amendments on Composition of Health Systems Agencies

Section 1512(b)(3)

(C) COMPOSITION. The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements.

(i) ~~A majority (but not more than 60 per centum)~~ Sixty per centum shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who ~~are broadly representative of~~ approximate the social, economic, linguistic, and racial, sexual, and elderly populations, geographic areas of the health service area, and major purchasers of health care (including labor organizations).

(ii) Fifteen per centum shall be residents of the health service area served by the agency who are elected public officials or persons appointed by elected public officials.

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~~(ii)~~ (iii) - The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities and health maintenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions, and VI non-professional health workers.

~~(iii)~~ (iv) - The membership shall -

(I) include ~~(either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and~~ representatives of public and private agencies in the area concerned with health.

(II) include a percentage of individuals who reside in non-metropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in non-metropolitan areas (including persons residing in rural settings), and

(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of

the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.

(IV) include (among its consumer members) at least one representative of the handicapped as defined in section 706(6) of title 29, United States Code, and in a health service area where a substantial number of persons have an identifiable occupational health problem, at least one representative of such group.

~~(iv)~~ (v) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall appoint a majority of consumers to such subcommittee or group and shall to the extent praticable make its appointments to any such subcommittee or group in such a manner as to provide the representation ~~on such subcommittee or group~~ described in this subparagraph.

(vi) Consumer members of the governing body of the agency shall be selected in a manner (approved by the Secretary) which provides for accountability to the population of the health service area served by the agency, sub-divisions thereof, or the population groups represented on the governing body, and not more than one-third of the total consumer members may be elected or otherwise selected by the governing body itself (or portion thereof). Providers shall not participate in the selection of consumer members.

STATEMENT OF STEVE SUITTS

Mr. SUITTS. Mr. Chairman and Mr. Carter, I am Steve Suitts. I am the executive director of the Southern Regional Council. For clarification I should stress that the Southern Regional Council is a private, not-for-profit organization located in Atlanta, Ga. Our overriding mission is to do what we can to promote equal opportunity for all peoples in the south.

While the Council has had an abiding concern for health care and has used its research tools to examine how well health care is delivered to southerners, in the past couple of years we have focused carefully on health systems because of their importance and their potential.

In the summer of 1976, we examined 28 health systems agencies in the 11 States of the old Confederacy. Our study which we have given this committee was conducted on the basis of the information that we gathered there. I do not want to go into the full findings of that report, but I do want to stress a few areas which we believe are most important and which have direct relevance to this committee's consideration [see p. 677].

We were most disturbed by the method of creation and organization of the HSA's. More than 80 percent of those HSA's which we surveyed were private, non-for-profit organizations which were self-appointed and self-perpetuating. There were very few provisions for public participation, and even some of those provisions which were in the bylaws were not very well observed.

The creation of most HSA's in these southern States went without the scrutiny of the public and with only minimal public participation.

We found as well that the composition of the governing boards does not, in fact, reflect the varying segments of the population that exist in these southern States and in the local populations where the HSA's existed. Perhaps not too surprisingly, we found that in most HSA's blacks were underrepresented and in no instances were there more blacks on any of these governing boards than there were in the population. In most instances the vote was noticeably below.

We found that women were vastly underrepresented. There were no provisions for and there were seldom any members from groups who have particular medical needs such as the physically disabled or the elderly.

All in all, on the governing boards of the HSA's which we surveyed there had been no initiative to actually reflect the communities and the various groups that make up the communities where these HSA's operate. Disturbing to us, also, was the fact that the staffs of the HSA's were not very reflective of the diversity of the community as well. Beyond clerical positions, to find a black or female in a professional position was a rare instance in these 28 HSA's which we surveyed.

I think these findings alone militated us to conclude that more emphasis needs to be placed upon either specific language or instruction to the agencies that these HSA's must reflect more accurately and broadly the segments of the population. I do not need to spell out to this committee the fact that these groups which I have men-

tioned are groups that have often special needs in the area of health care. Our survey shows that they are the groups which have been largely underrepresented.

I should point out, Mr. Chairman, that it is not an easy duty for any consumer, especially one who is poor, and there are very few poor folks on HSA's and even fewer folks who represent poor peoples organizations, but it is not very easy to be a consumer member of this governmental body or quasi-governmental body.

We found that transportation is often a problem. There is certainly not a uniform policy of HSA's to reimburse anyone on their boards for travel. Some of the distances in the south and elsewhere in the country amount to round trip travel of as much as 200 miles to attend meetings of the governing board or to attend subcommittee meetings.

We also found that such things as lodging were seldom provided. So, the fact is, Mr. Chairman, that even those folks, who are on HSA's and who do reflect these groups which are largely underrepresented, are having a hard time doing their work conscientiously because of the obstacles that may exist.

The result, I think, is that HSA's are operating in the south and elsewhere without the kind of representation from these groups that is needed. I think a conscientious examination of amendments that need to be in the law would require that these areas be given attention by this committee.

Thank you, Mr. Chairman.

[Testimony resumes on p. 684.]

[Mr. Suitts' prepared statement follows:]

STATEMENT OF STEVE SUITTS, EXECUTIVE DIRECTOR, SOUTHERN REGIONAL COUNCIL

Mr. Chairman:

My name is Steve Suitts and I am the Executive Director of the Southern Regional Council located in Atlanta, Georgia.

The Council is a not-for-profit organization which has worked since 1944 to promote equal opportunity for all peoples in the South through research, education, and action. Following this mission, the Council has been especially concerned for many years about the health and well-being of southerners, particularly those who are poor, black, or uninfluential. During the past ten years, the Council has examined closely the problems of nutrition and hunger in the South and has published several reports on the status and delivery of health care. In 1974, the Council produced Health Care in the South: A Statistical Profile which for the first time brought together important, recent information about the problems of health care in the southern region.

In the past few years, a special project of the Council, the Southern Governmental Monitoring Project, has assessed first-hand how well programs and services sponsored by the government have been available to all. Spurred by the development of new federalism, the Project in the past few years has examined access by the poor to health care in Hill-Burton hospitals in the South; Medicaid for the young; and health planning agencies in the South.

This most recent report based upon an assessment of information gathered in the summer of 1976 examined 28 health systems agencies (HSA's) in the eleven states of the old Confederacy. The study was conducted to obtain information on the developments of health planning in the South, the election and composition of the governing boards in the early period upon which mechanisms and processes will be established. Our findings in that report have a direct relevance to questions which are faced by this committee in considering any amendments to the National Health Planning and Resources Development Act.

(1) METHOD OF SELECTION: While there were exceptions to the rule, most governing boards of HSA's which we surveyed were created with only a minimal regard for public participation and seldom with any involvement from various segments of the local population. Most of the health systems agencies are private, not-for-profit organizations which were self-appointed and will be self-perpetuating. Only one HSA in the South - located in Georgia - has its governing board selected through public election.

(2) COMPOSITION OF THE GOVERNING BOARDS: The Council's Monitoring Project survey found that in the large majority of cases consumers did constitute a majority of the governing

boards; however, there were enough instances of firm, established relationships between some of the consumers selected and medical providers that questions arose about whether, in fact, consumers constituted the largest influence in decision-making.

Equally important, our survey found that the consumers on the governing boards were not "broadly representative of the social-economic, linguistic, and racial populations . . ." In these southern HSA's surveyed, we found that blacks, women, and the poor were underrepresented almost uniformly and at times dramatically.

The pattern of consumer representation on these governing boards was unbroken: blacks and other minorities in the South were never represented noticeably above their proportion in the local population and most often were below it. In some states, such as Louisiana, the variances remain significant. In others, the most minimal representation was adjusted upward only after questions were raised before designation by the Department of Health, Education, and Welfare. In all cases, women were significantly underrepresented. In the mid-Louisiana health systems agency, for instance, there were only two women on the entire 30-member governing board. Most of the other HSA's which the Council surveyed evidenced a similar underrepresentation of women.

While there were occasionally members of the governing board who provided social services to the poor, there were seldom any instances of poor folks becoming members of HSA governing boards. Few boards had anyone serving with an income less than $10,000 and even fewer had anyone selected to the board because of their membership in an organization composed of poor folks.

(3) COMPOSITION OF HSA STAFFS: Although we were unable to acquire precise information on all of the staffs of the HSA's surveyed, the available information which we did gather showed blacks, other minorities, and women were underrepresented by an even wider margin on the staffs of the health systems agencies. Beyond the clerical ranks, the employment of blacks and women was a rare event.

These findings were released in the middle of last year in a report entitled Placebo or Cure? State and Local Health Planning Agencies in the South. I am submitting copies of the report for the record. It is important to note that our work does not pretend to be a substantive assessment of the decision-making which HSA's carry out. At the time of our study, few decisions had been made and little planning was actually underway.

Our research does stand as a warning that the method of

selection and the composition of the governing boards and staff of HSA's do not reflect accurately or broadly the elements of the local population in which they exist. Our preoccupation with selection and composition is based upon the view, seasoned by our experience and confirmed by other governmental regulatory systems, that a decision-making procedure that affects so many people directly can work best when most representative.

Questions of selection and representation must be weighed with the recognition that the delivery of health care in the South and elsewhere has been the most deadly problem of the poor, blacks, other minorities, and women. While I need not inform this committee of the enormous body of information which substantiates the peculiar and direct problems of health for these affected groups, their meaning needs to be reiterated. For folks who have had substantial and sometimes unique problems in receiving health care, the best way to insure that decision-making includes their interests is to include them proportionately in the decision-making itself. This principle must be upheld in fact by precise language and exact, high standards requiring the representation of these identifiable groups in proportion to their population in the areas where HSA's operate.

Beyond the disparity between the local population and HSA's board composition, the rationale for an exact standard of representation is also supported by the actual procedures and influences which exist in most HSA's. Because of the absence of blacks, other minorities, and women in the ranks of medical professions, these groups are seldom represented as medical providers on governing boards of HSA's. Because of the dominance of professionalism and expertise at this stage of health planning, there is also a likelihood that the views and influence of these affected groups will be further diminished.

There are other obstacles to the participation of consumers especially those representing groups of minorities and the poor. Many of the meetings of deliberative committee and sub-committees of the governing boards are held during the daytime when consumers find it difficult to attend. For others, there are distances which extend to almost 200 miles and which must be travelled to attend meetings. Reimbursement is not always available. Also, there is seldom any clerical assistance available to individual board members.

The reality of how the health systems agencies actually work and the impediments which they include offer further reasons to establish by legislation a precise standard for the direct representation of the poor, blacks, other minorities, and women.

The conclusions which we reached in our study and which we urge upon this committee today should not be read to discount every decision which a health systems agency has made under the 1974 legislation. Obviously, there is much that should be maintained and there have been decisions which are the products solely of reasoned discussion. Still, unless Congress insures that these agencies are selected in the manner which is representative and are composed of representatives reflecting the various segments of their communities, the agencies will fail to meet the most vital needs of health care for our citizens. The South and this country have learned painfully the failures and calamities which we suffer when groups are excluded or grossly underrepresented. I hope that this committee will heed that lesson today.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Checkoway.

STATEMENT OF BARRY CHECKOWAY

Mr. CHECKOWAY. My name is Barry Checkoway. I am assistant professor of Urban and Regional Planning at the University of Illinois at Urbana, Champaign. I am also a leader of the Champaign County, Ill., Health Care Consumers.

I would like to summarize my comments and submit my full statement and documents for the record [see p. 686].

My statement describes the local constraints on public involvement in health care planning under the Federal law. These are not the only local constraints of concern, but they are among the most important.

The first constraint is the failure of consumer majorities on HSA governing and supporting bodies to approximate their area population. A recent report of a 3 month study of the East Central Illinois Health Systems Agency found this to be the case. This HSA is divided into five subarea advisory councils "to provide the maximum potential involvement of the public." Among the findings were that of 30 members of one subarea advisory council selected for analysis, 24 were from the highest income census tract, only one was from the lowest income census tract, and no low income minority or rural area was actively represented. Attendance at meetings was found so inadequate that one-half of the board should have been terminated by its own bylaws. Among the conclusions were that the agency appears to give preference to people of a higher socioeconomic status and that there is immediate need for more public involvement. Follow up studies in our area have found that the regional HSA governing body is also representative of the area population, especially in regard to low income persons and women. Studies elsewhere around the country have found that in case after case providers and other vested interests have moved in and taken control over local HSA's.

The second constraint is the failure of HSA's to allow effective public involvement in agency proceedings. The public law placed an emphasis on public notice and open meetings, on local accountability and consumer involvement. But the East Central Illinois HSA, for example, refused to conduct hearings to allow public comment and consumer involvement in developing the project review manual. In December this HSA also decided "that 5 minutes be allotted for public comment for each substantive item on the agenda of board meetings." What this effectively means is that in our 16 county, more than 10,000 square mile area, public involvement from consumers, providers, labor unions, women and minority groups, religious bodies and local elected officials will be restricted to only 5 minutes per agenda item. Some agenda items involve public expenditures of hundreds of thousands of dollars. The agency at present has no specific plans to involve and benefit medically under served population groups.

The third constraint is the failure of HEW to intervene in local cases where it is believed that HSA's are not in compliance with Federal Government aims and with democratic principles. The HEW

responses to our report of the compositional failure of our local HSA were as follows: The director of the Bureau of Health Planning and Resources Development in Washington thanked the researchers for sending him a copy of the report and promised to forward it along to the Chicago regional office. The deputy director of the Chicago regional office also thanked the researchers and promised to forward the report along to the project officer of that office. A regional program consultant of that office in Chicago, wrote to us that after reading the report he contacted directly the local HSA staff and was informed that the researchers had not afforded the courtesy to the HSA to review the report prior to its release, that they lacked knowledge and understanding of the public law, and that the report had errors and inconsistencies. His conclusion was "this office feels that it would be inappropriate to comment on the substance of the report or to take the conclusions under consideration." I wrote in response to describe the thorough research on which the report was based, to explain that following his letter an additional interview was held with the HSA executive director and no errors inconsistencies were found, and to reaffirm that there was no evidence to place its accuracy in question. I pointed out that his information was incorrect and urged him to discuss the matter further with us. No further response from regional HEW was ever received.

I hasten to add, however, that the consumer responses in comparisons were extensive. Local consumers learned of the report and began meeting to discuss its findings. We resolved to organize to improve the local situation and have now formed the Champaign County Health Care Consumers. We have determined to join the local HSA in great numbers, to increase our involvement on its governing boards and committees, and to speak up and argue our points at hearings and meetings.

In a recent election of the HSA subarea advisory council we enlisted and endorsed consumer and provider candidates with competence in promoting good health and improving local health planning. Of the 12 contested seats, fully, seven of our endorsed candidates were elected and now have joined the council. All this in spite of the internal hospital memorandum on the day of the HSA election: "Urgent! The future of your hospital depends on your attendance at tonight's HSA election."

We believe that major improvements in health and health care planning will come only with the involvement of the public. We will continue to work to improve health care legislation and implementation under the public law. But we also believe that it would be a strategic mistake for us as consumers to organize only with reference to the HSA without an organized and independent agenda of our own. As a result, we are now deciding on the concerns which are important to us as consumers and we are aiming to turn the local health care planning system in our direction. Providers have taught this lesson for years.

[Mr. Checkoway's prepared statement follows:]

PUBLIC INVOLVEMENT IN LOCAL HEALTH CARE PLANNING

Barry Checkoway
Assistant Professor of Urban and Regional Planning
University of Illinois at Urbana-Champaign
Champaign County (Ill.) Health Care Consumers

Prepared Statement
U.S. House of Representatives
Subcommittee on Health and the Environment
Washington, D.C. 20515
February 1, 1978

My name is Barry Checkoway. I am an Assistant Professor of Urban and Regional Planning at the University of Illinois at Urbana-Champaign and a leader of the Champaign County (Ill.) Health Care Consumers. My aim here is to describe the constraints on public involvement in local health care planning under PL 93-641. I also wish to submit supporting documents for the record.

Early in 1977 a group of my students at their own initiative conducted a three-month study of public involvement in local health care planning. The focus was on the East Central Illinois Health Systems Agency (ECIHSA). This HSA is divided into five subarea advisory councils (SAC) "to provide the maximum potential involvement of the public." Among the findings were that of 30 members of one SAC selected for analysis, 24 were from the highest income census tract, only 1 was from the lowest income census tract, and no low income, minority, or rural area was actively represented. Attendance at meetings was found so inadequate that one-half of the board should have been terminated by its own by-laws. Among the conclusions were that the agency appears to give preference to people of higher socioeconomic status and that there is an immediate need for more public involvement.

The report of the study was presented to the Champaign County Regional Planning Commission, acting as the area A-95 review agency to review the application for second-year conditional designation of the ECIHSA. It also was sent to the HSA itself, to Executive Committee members of the Statewide Health Coordinating Council (SHCC), and to HEW officials in the region and Washington.

The official responses were as follows. The Regional Planning Commission reviewed the matter and the chair of the Commissioners, who represent the major units of local government in Champaign County, wrote to the ECIHSA that "the composition of the sub-regional advisory committee is not representative of the citizens of all areas of the County, and appears to give preference to people having a higher socioeconomic status" and that "the individuals representing the agency are responsible to no one and this is not in keeping with the democratic process." The Commissioners approved the application but resolved that steps should be taken by the ECIHSA "to specify within the by-laws that Board members be duly appointed by the groups which they are presumed to represent" and "to make an expanded effort to achieve broad citizen input into the planning process at all levels."

The ECIHSA implemented minor modifications. Four SAC members whose attendance was inadequate were requested to leave the board. A public relations consultant was contracted to produce a slide show for the agency. The agency readied to mail out its first newsletter.

Only one member of the SHCC Executive Committee wrote to express concern but no action was taken. An offer to attend a SHCC meeting to discuss the report was ignored by the Executive Committee.

The Director of the Bureau of Health Planning and Resources Development of HEW thanked the researchers for sending him a copy of the report and promised to forward it to the Chicago regional office. The Deputy Director of the Chicago regional office also thanked the researchers and promised to forward the report to the project officer of that office. A regional program consultant of that office wrote that after reading the report he contacted the ECIHSA staff and was informed that the researchers had not afforded the courtesy to the HSA to review the report prior to its release, that they lacked knowledge and understanding of PL 93-641, and that the report had errors and inconsistencies. His conclusion was "this office feels that it would be inappropriate to comment on the substance of the report or to take them under consideration." I wrote in response to describe the thorough research on which the report was based, to explain that following his letter an additional interview was held with the HSA Executive Director and no errors and inconsistencies were found, and to reaffirm that there was no evidence to place its accuracy in question. I pointed out that his information

was incorrect and urged him to discuss the matter further. No further response from regional HEW was ever received.

The consumer responses in comparison were extensive. Local consumers learned of the report and began meeting to discuss its findings. My students and I were among them. We shared our concern about the failure of local health care planning and other issues as well. We shared our concern that health care costs continue to rise because of waste, inefficiency, and excessive production in the health care system. We shared our concern that in case after case providers and other vested interests have moved in and taken control over health planning agencies. It was at this time that we met with representatives of the Association of Health Care Consumers and the Consumer Coalition for Health and resolved to organize to improve the situation.

Local consumers now have formed the Champaign County Health Care Consumers. We are an organization of local citizens concerned about improving health care delivery to all residents of our area. Our aim is to participate in health care planning by promoting public involvement. We have determined to join the local HSA in great numbers, to increase our involvement on its governing boards and committees, and to speak up and argue our points at hearings and meetings.

The Champaign County Health Care Consumers is now a growing organization of consumers who believe that health care is too important a matter of public concern to be left solely to those who provide it. More than 100 people have attended each of our recent health education forums. We are sponsoring consumer education workshops for HSA board and SAC members to address issues of importance to consumers. In the recent election of the SAC, we enlisted and endorsed consumer and provider candidates with demonstrated competence in promoting good health and improving local health care planning. Of the twelve contested seats, fully seven of our endorsed candidates were elected and will now join the council. An independent health consumer organization can make a difference.

Among our current concerns is the ECIHSA application to HEW for full designation as the HSA for our area. It concerns us that the composition of ECIHSA governing and supporting bodies remain unrepresentative of the area population, especially in regard to low income persons and women. It concerns us that the ECIHSA has no specific plans to involve and benefit medically underserved population groups, or to recognize labor unions as major purchasers of health care, or to employ qualified full-time consumer coordinators with major responsibility to maximize public involvement in health planning. It

concerns us that the ECIHSA budget is excessive and priorities misdirected in a period when the costs of health care are rising.

It finally concerns us that the ECIHSA has no specific plans to allow effective public involvement in agency proceedings. PL 93-641 placed an emphasis on public notice and open meetings, on local accountability and consumer involvement. But the ECIHSA refused to conduct hearings to allow public comment and consumer involvement in developing the Project Review Manual. And in December the ECIHSA decided "that five minutes be allotted for Public Comment for each substantive item on the Agenda of board meetings." This effectively means that public involvement from consumers, providers, labor unions, women and minority groups, religious bodies and local elected officials from our 16 county area will be restricted to only five minutes per agenda item. Some agenda items involve public expenditures of hundreds of thousands of dollars. These are not our only concerns, but they are among the most important at this time.

We believe that the ECIHSA is not in compliance with federal regulations and democratic principles and that HEW should not fully designate the agency until these and other failures are corrected.

We believe that major improvements in health and health care planning will come only with the involvement of the public. We will continue to work to improve health care planning legislation and implementation under PL 93-641. But it would be a strategic mistake for us to organize only with reference to the HSA without an organized and independent agenda of our our own. We thus are deciding on the concerns which are important to as consumers and aiming to turn the local health planning system in our direction. Providers have taught this lesson for years.

Mr. Rogers. Thank you very much.
Mrs. Fenerty.

STATEMENT OF ANNE FENERTY

Mrs. Fenerty. My name is Anne Fenerty. I am a member of the Central Northeast Colorado Health Systems Agency, which is located in Denver, Colo., and takes in a population of 1.8 million people, and it is funded this year, in its second year conditional designation to $750,000.

I am here to tell you about the frustrations that I encountered in my attempts to make the HSA respond to the public. This HSA was formed in December 1975 by 16 people who then subsequently incorporated themselves as such.

The 16 people called themselves a steering committee and this steering committee was headed by a registered lobbyist of the Colorado Hospital Association. The 16 member steering committee is still on the board. They make up the officers of the board, the chairman of the Plan Development Committee, the chairman of the Projects Review Committee, the internal nominating committee and the chairman of the Finance Committee. They also have multiple important committee memberships on other committees.

This seems to result in control by this original group and this in turn results in the resignation of many people who had hopefully joined the HSA because they would like to change the financial reimbursement mechanism to be more adequate for all people.

The kind of people who resigned were three county commissioners, one of whom was a lawyer also, and a city council woman from Denver, a legal aid attorney, and we had a lot of people representing poor people directly, who resigned, such as a nun who was serving the aged and poor in Denver, a teacher of the epileptics, and a truck driver who was a teamster.

There is very little board training. Most of the board members are not told what their function is on the board apart from being given a copy of the law. Regulations are not sent out and the board is not informed of its duties.

The meetings are held early in the afternoon. The monthly meetings are at 1:30 p.m. Very many people who work cannot get to the meetings.

It is very difficult to have input into board policy because there really is no mechanism afforded to the members. This is something which has been brought to light by the regional HEW assessment of the HSA.

The board policy functions are loose. What happened was that I felt that things were extremely irregular and took a course in the parliamentary process. As a result of that, the board now hires a parliamentarian to keep an eye on me.

It is very difficult to get information from the staff. Phone calls often are not returned. Letters are answered by saying, "Please stop burdening the staff with requests." This referred to a request for a copy of the quarterly report of the agency.

There is no public input into the deliberations of the board because there is very little notice of board meetings. What we have is two notices in the legal section of the Metropolitan Denver newspapers. People do not really read the legal sections. Also CNCHSA covers a 20-county area, a very large area of Colorado.

The other areas get no notification. At the second-year grant application meeting we had three people, representing the public, present. Only officers of the board were there and five of us board members. It was very difficult to get a copy of the grant application.

When the grant application was submitted for the second year of conditional designation to HEW, and this was advertised in the legal notices, I asked for a copy of the grant application which bore my name as one of the applicants, and was told by the executive director that I will have to pay $0.03 per page to get a copy of the grant application for the agency of which I am a member of the board of directors.

The board is generally viewed as arrogant by the public. Again this is a direct quotation from the regional office assessment of the board. Generally the reason for that is because the staff comes out with plan development problems, for instance, with one proposal, and you can vote for or against it, there are no choices and no policy decisions made by the board.

We do not have any subarea councils. We have 46 associate members who cannot vote on either the board or the committees, 41 of whom are providers, and 5 consumers. The board abdicates its responsibility and there is a total lack of interest in the functioning of the board, by its members.

On June 23 within a 10-minute period, the board approved contracts to the tune of one-fourth of its total yearly budget to be given away. These contracts were submitted to us as agenda item No. XII, under the executive director reports. We had no previous notification of the contracts. We were supposed to read them and make a decision on them right there.

The reason given for this was that the fiscal year for the agency has just about come to an end and if we did not spend the money, it would have to be returned to HEW. I felt that this was incomplete justification for having to break the bylaws, which provide for a 10-day previous notification period before making any decisions especially on that amount of money.

We managed to get HEW to nullify one of the contracts on the basis of conflict of interest with the executive director who had a conflict of interest with one of the contractors.

The last item I would like to point out is that we have had an illegal board now since April 1976. We have had a provider majority board since 1976. Our annual election on December 19, 1977, was held by a board that had provider majority and we have elected a new board with a provider majority.

We have talked to the regional office of HEW about this special problem and other problems but really have had very little help. Finally, several board members have had to contact our elected officials. We saw the two Congressmen whose areas take in our agency and two of our senators.

We have talked to the principal regional officers, and I think as a result of the congressional interest, plus the fact we now have a new principal regional officer, HEW in its assessment reflecting all our concerns, indicted the agency for basic disorganization, mismanagement, and arrogance toward the public.

What I am trying to say here, Mr. Chairman and Mr. Carter, is that for just one board member or three or four of us board members, it is extremely difficult, as stated before, to spend the time and effort that we have to make the regional office more responsible for the taxpayer's money.

Thank you.

[Testimony resumes on p. 703.]

[Mrs. Fenerty's prepared statement follows:]

STATEMENT BY

ANNE FENERTY

ON BEHALF OF THE

CENTRAL NORTHEAST COLORADO HEALTH SYSTEMS AGENCY (CNCHSA)

ON H.R. 10460

HEALTH PLANNING AND RESOURCES DEVELOPMENT
AMENDMENTS OF 1978

BEFORE THE
HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

My name is Anne Fenerty.

I live at 2805 Stanford Avenue, Boulder, CO 80303.

I have been involved in health planning in an effort to change the present financial reimbursement mechanisms for health care.

My special concern is the heavy spending for institutional, often custodial care, for older and disabled people in nursing homes.

I have been involved in alternative programs to help prople achieve their maximum level of independence.

Due to this interest I have followed Comprehensive Health Planning activities, and testified at hearings. Since May 27, 1976 I have been a consumer member of the Central Northeast Colorado Health Systems Agency.

This testimony is presented to document facts, issues, and concern in regard to the Central Northeast Colorado Health Systems Agency (CNCHSA).

The original steering committee for CNCHSA was organized in December 1975, and was chaired by a registered lobbyist of the Colorado Hospital Association, to whom applications for board membership had to be sent. All sixteen of the original steering committee members are still on the CNCHSA board today. They make up the officers, and the chairmen of the plan development, project review and the finance committee. They also hold a number of other, important committee memberships.

Since the bylaws allow the President to nominate all committees, some board members find themselves on multiple committees, while other members have been on the board for well over half a year without becoming involved in a committee. As pointed out in the HEW site assessment, CNCHSA bylaws mandate a clear description of the purpose, membership, and duration of a committee. Because this has never been done board members are unclear about their role on the committees. This has often resulted in a lack of quorum for the committees; thus violating this provision of the bylaws. When it was pointed out to the board that a decision made by, say, three members of a fourteen member project

review committee is illegal and might, in the future, leave the board liable, the board member was called an obstructionist. The President pointed out, at a Project Review Committee meeting when this subject came up, that: "We are here to serve these people," i.e., the applicant, meaning that expediency dictates our making a recommendation whether a quorum is present or not.

Since there has been very little board training, the regulatory function of the agency in unclear to most board members, and their sympathy is with the applicants. The majority of projects are overwhelmingly approved. Despite the lack of a project review manual, and of a data base, the project review committee has chosen to exercise its review and comment function for Certificate of Need, Section 1122, and Proposed Use of Federal Funds applications, since August 1976. (PUFF only since August 1977). There is no consultation with local public or private agencies involved, and no effort is made to notify "affected persons", save legal notices in two Denver newspapers. No notice goes anywhere else in the 20 county HSA area.

Public input, or the lack of it, is a major problem. Counsel to the board interprets the Federal Register as mandating that the public be allowed to be present at meetings, but that it "must not interfere", i.e., speak at the meetings unless the Board agrees to it.

The Board has no subarea councils (SACs), even though their establishment was one of the 01 year grant conditions. The need for SACs has been discussed, and is found in board minutes as far back as April 9, 1976.

The Associate Membership category has been established recently. Associate members have no vote at either board, or committee, meetings. We presently have 41 provider, and 5 consumer associate members.

HEW site assessment team reports that CNCHSA is viewed as arrogant by the public. The idea of a publicly funding agency planning, and reviewing projects without consultation with local, regional and state agencies is becoming generally unacceptable. Comments on the 02 year grant application were negative from the Denver Regional Council of Governments, and from two major County Health Departments. Only three members of the public were present at the Denver public hearing for the grant application. The application was sent to the Regional HEW Office, and notice of the hearings was given, in the legal section of two newspapers, but board members, who are legally responsible for it, were not given a copy of the application. A board member was charged 3¢ per page, by the Executive Director, to get her copy of the application.

Board members are not informed of correspondence between CNCHSA and the Regional Office of DHEW, and get no copies of the quarterly reports. Inquiries are discouraged by any

of the following methods:

(1) Lack of mechanism for policy discussions at board meetings;

(2) Letters from the President asking board members to stop making requests of staff. Note: CNCHSA is funded to $750,000 for this fiscal year, and has a professional staff of 18;

(3) Charging board members for information;

(4) Unreturned phone calls by staff.

Much of the information obtained by us came through the Freedom of Information Act.

CNCHSA board has had a provider majority since April, 1976. The board with this provider majority has elected another provider majority board at its annual meeting December 19, 1977.

The composition on the provider side is heavily weighted toward hospital representation. The "continuum" of health services is missing, with a resultant domination by the hospital and medicaL providers. Consumers are inadequately represented in the low-income and younger age groups. The 01 year grant was awarded in June 1976, but only by December 19, 1977 has the 61 member board elected one "major purchaser of health care", representing industry.

Board and committee meetings held in the early afternoon, plus frustration caused by the domination of a group, results in the resignation of many concerned, knowledgeable

consumers. A board member, the newly appointed Director of the Colorado State Department of Social Services, is quoted in the December 19 board minutes: "This board is run by a clique."

Resignations: Since May 1976 only three providers left the board: one moved away, one resigned his job with Blue Cross/Blue Shield, and one died. Numerous consumers left the board: three County Commissioners; one of whom is a lawyer, the other an ex-president of the League of Women Voters, two labor representatives, one of whom is a truckdriver and a Teamster, the other a legislator; along with a young teacher of epileptics, a nun serving the urban poor, and a Legal Aid attorney. Because of the frustrations of an involved board member, the consumers who stay on the board are those who were invited by, and who defer to, the providers. Some are well-off women, exemplified by the board president, who is the Mayor of Denver's wealthiest incorporated suburb, and many others are retired.

Total lack of interest and abdication of its responsibilities by the board, resulted in board approval of $112,475 worth of contracts within ten minutes at the June 23, 1977 meeting. Since the board meeting took place a week before CNCHSA's fiscal year ended the Executive Director felt that this money had to be spent, rather than returned to the federal governemnt. Therefore, under Agenda Item XII,

the Executive Director's report, staff passed out copies of three contracts, 27 pages in length, for which the Executive Director has already made tentative arrangements. There were no requests for proposals solicited, and questions were raised concerning Affirmative Action guidelines. The bylaws provision requiring ten days previous notice to board members on items which require action taken by the board was violated, since there was no previous notice. In spite of these concerns the majority of the board approved the contracts. The first one for $67,475 was to develop a framework for a primary care system which would incorporate a nurse midwifery service. A second contract for $25,000 was to evaluate the concept of Subarea Councils, and the third one was to develop a method to describe the health care delivery system. In addition to the already mentioned concerns other issues arose:

* The surplus money, about one forth of the 01 year grant has been an unobligated balance on the books since 3/16/77. Why have there been no plans made earlier?

* Could the work be implemented by inhouse staff, now numbering 28?

* Why was there no consultant policy adopted by CNCHSA?

* Was there no one in Colorado capable of performing the job awarded to a Louisiana firm for $67,475?

It was later documented that the Louisiana firm has retained the Executive Director, who is from Louisiana, as a faculty consultant, before her employment with CNCHSA. She also served on the board of the firm until June 1977. The firm has not filed corporate papers in Louisiana since 1973, nor has it ever filed in the State of Colorado. Also there was an active group of nurse midwives, based at the University of Colorado Medical Center, who along with the Chairman of the school's Obstetrics-Gynecology Department, expressed great interest in the contract, when they found out about it.

The two other contracts, along with a fourth separate auditing contract, were awarded to Arthur Young and Company. This firm has already been paid by the Regional Office of DHEW to develop a Planning Framework Manual for CNCHSA, and to do an executive search for $30,000 which resulted in hiring the Executive Director. They were paid $1,800 in March 1977 to "set up" the Agency's books. The contracts awarded June 23, 1977 resulted in the firm auditing the books they had set up, and, in one of the contracts, evaluating their own plan development method.

Improvement of the present lack of organization and lack of planning can only be achieved by a more concerned and responsible board. Unfortunately the selection process for one third of the board members whose terms expired at the December 19 annual meeting was totally inadequate and

resulted in the renomination of the same board members. The President formally discharged the nominating committee, a violation of the bylaws, and this prevented any recruiting for new members. When the committee was reconvened no time was left for community outreach. There were very few applicants, and as a result of 21 members named to the board 13 were renominations. Since the nominating committee refused to accept another slate of officers, all officers excepting one consumer-oriented provider, were renominated. The result is that the board self perpetuated itself.

Concerned board members contacted the Regional Office of DHEW and were informed that the financial and internal affairs of CNCHSA were not DHEW's business. Since there seemed no accountability regards the taxpayer's money we contacted those members of Congress who represent most of the CNCHSA region, and also our Senators. Possibly, due to their intervention, and due to the appointment of a new Principal Regional Officer the site assessment done by the Regional Office of DHEW did reflect our concerns. These issues were also corroborated by 50 other interviewees.

It has come to our attention that an attempt was made to supress the assessment report by preventing its distribution to all board members. The officers also tried to persuade the DHEW assessment team to change its findings.

The amount of time and effort spent by a few of us on the CNCHSA board to get issues to our board, to the

Regional Office of DHEW, to the media, and to our Congressional Delegation is not feasible for the majority of HSA members.

The fact that after its own assessment which indictes the agency, the Regional Office of DHEW still states that it will "bend backwards" to help CNCHSA get permanent designation does not auger well for the future of health planning.

Mr. Rogers. Thank you very much. Your testimony is helpful. The committee will check into this.

Doctor Carter.

Mr. Carter. Thank you, Mr. Chairman.

Do either or all of you think that we should require that 25 percent of the board of the HSA be elected officials?

Mr. Semmel. Perhaps I can answer that. The consumer coalition has recommended that 15 percent of the HSA board members be elected officials. We think that would be desireable for two reasons.

One is that there should be involvement of local officials. The second is that at present there is a lot of confusion as to whether elected officials on HSA boards are consumers or providers because indirectly most governmental agencies operate some health facilities.

In practice we have found that most public officials are regarded as consumers except when there is someone like the head of the Department of Health. So we think there should be a separate category although we think the number 25 percent is perhaps too high.

Of course we think the principle of consumer majority should remain and the balance of the board should be 15 percent public officials and the remainder providers.

Mr. Carter. I believe that the percentage is about that now, isn't it?

Mr. Semmel. The percentage is approximately that now, but there is a great variance, in some areas a very high percentage.

Mr. Carter. Yes. How would you suggest that members of HSA be elected or selected? I would prefer elected.

Mr. Semmel. I think that there are a number of different ways in which members could be elected. A general election in which all members of the public can participate is certainly one method which is possible.

As a variation of that, since most of these organizations are nonprofit corporations, any member of the public can become a member of the corporation and the members elect the board. In fact, you sort of register to vote by becoming a member.

Other alternatives are to elect subarea councils which in turn will send delegates as members of the full agency board. In some cases it might be desireable to have organizations representing different population groups select members of the board.

It may be appropriate in some cases to have government officials select some members so long as they do not dominate the board.

The principle that we feel should be followed is accountability to the public. The legislation should make that clear. Then it should leave to each HSA within that framework, the flexibility to choose the one that best fits their needs.

Mr. Carter. Do you feel that the consumer should have technical training so that he can become a good member, a more efficient member?

Mr. Semmel. There are two aspects to that, Mr. Carter. One is training, but we also feel independent technical assistance is necessary. It may also be necessary for some of the providers that do not have backup support from their own institutional staffs.

When you get a thick application for a certificate of need, when you get an application for a health service plan for the area, it is

important that members of the board have someone that they can discuss these things with, get their questions answered, so they can understand the key issues.

The staff of the HSA has a difficult role to play and there should be an outside adviser available to the members of the board.

Mr. CARTER. I do not think that any of us believe in self-perpetuating HSA's, but how do you account for such a low selection of consumers and such a narrow spectrum of consumers? How do you account for that?

Mr. SUITTS. I think it is related to how the HSA's were created. The law has allowed agencies to create themselves by incorporation and thereafter to self-perpetuate.

I think HEW has been at best very mixed in enforcing any kind of understandable uniform standard of what is reflective of the community. I think the creation and selection process is not very open, Mr. Carter.

Mr. CHECKOWAY. In addition, I believe that for years providers have had professional networks, supportive staffs, and other institutions which have enabled them to be effectively organized. Therefore, when this health planning legislation began to be implemented, it advantaged them in particular in turning it toward their own ends.

Consumers, on the other hand, approach the health care system as individuals or only in times of need, and rarely have had the backup services and institutions available to providers. It thus seems not accidental that HSA's would become dominated by providers. It also seems not accidental that HEW would be more responsive to organized providers.

Mr. CARTER. Do you think that any health providing group should turn anyone away because he does not have the money?

Mr. CHECKOWAY. I do not believe that any health provider should turn any member of the public away regardless of income or ability to pay, race, or sex.

Mr. CARTER. Do many of them do this today?

Mr. CHECKOWAY. There is documented evidence to suggest that they do.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. The point that you have mentioned will be looked into.

I think, Mrs. Fenerty, we will turn your testimony over to the Inspector General and get a report.

I am somewhat encouraged, Mr. Checkoway, that the present procedure allows you to get 7 out of 12. At least the procedure is not so bad. It is just a question whether the people will take an interest. Is that the case?

Mr. CHECKOWAY. I think that the current circumstances and procedure make it relatively easy for providers to dominate. My understanding is that our success is exceptional and should not be taken to typify the situation elsewhere.

Mr. SEMMEL. May I comment that it was in the subarea council that they won 7 out of 12 seats because there was an election. The agency board is a self-perpetuating board in that area. Am I right?

Mr. CHECKOWAY. I would also add that organized consumers have no representation on the regional governing board, which has the decisionmaking power in our area.

Mr. ROGERS. Has there been an effort to try to get on it?

Mr. CHECKOWAY. There will be such an effect. As with many other consumer organizations in this field, we have been operating only within the last year.

Mr. ROGERS. That is true in the whole system. We have just set it up, you know some HSA's are barely a year old, so it is an evolving process. We have written into the law that the majority be consumers, not more than 60 percent. So, we would be able to have that carried out.

Now we also have a provision in this bill which says they should not be self-perpetuating, which I agree with.

I notice in your statement:

We have included in our proposal language which will allow the consumer members of an HSA governing body to choose up to one-third of the total consumer members selected.

Now that sounds as if you would have the consumer members self-perpetuate, but no one else.

Mr. SEMMEL. The consumer members would not perpetuate because two-thirds of the consumer members would be chosen by a publically accountable process. The reason we reserve the third is that we were concerned that in some cases the process would not result in a broadly representative board.

Accordingly, the two-thirds that were elected by an accountable process could then choose the remaining one-third, if necessary, to reach the broadly representative result. So, we thought this would facilitate achieving that within an essentially democratic and accountable framework.

Mr. ROGERS. I presume the providers might come to us and say the same thing.

Mr. SEMMEL. The providers do not have quite the same kind of problem.

Mr. ROGERS. They may. They may say, "We do not have any hospital people on here. We do not have this provider group represented." So we will look at this carefully.

Mr. SUITTS. There is a diversity of providers, people with varying interests.

Mr. ROGERS. As there are with consumers.

Mr. CARTER. Mr. Chairman, we had a complaint from the dentists as to their representation on the board.

Mr. ROGERS. The dentists complained they were not getting enough of their members on the board?

Mr. CARTER. Sometimes hospital administrators, sometimes nurses.

Mr. ROGERS. That is right. So what we have tried to do is set it up so that people can participate. We can encourage participation and they have an opportunity to participate.

I was impressed by your testimony, Mr. Suitts, on the proportional representation. Is it better for us to have all elected representatives of the people run these things? We thought it was better to divide it up whether you have providers, governmental people and consumers rather than say it ought to be an elected body. I am not sure you can always get exact proportional representation. It is a goal to be desired, I am sure, but I am not sure how we can accomplish it.

Mr. SUITTS. I think you are right. I get a little suspicious when those groups are always underrepresented.

Mr. ROGERS. What about your elected body? You might even find that pattern there, I would think. Do you disagree with that? Certainly in the area you have looked at.

Mr. SUITTS. We have been involved in reapportionment litigation in the south for a good number of years trying to deal with that problem.

Mr. ROGERS. Even with elected people you have this problem. So we need to be conscious of these problems, I would agree, and I think you have pointed out very effectively some of the things that the committee needs to look at.

Thank you for your presence here. It has been most helpful to have your testimony.

Mr. SUITT. Thank you, Mr. Chairman.

Mr. ROGERS. Because of people having to catch planes, we are asking the panel of provider representatives to testify next.

We welcome each of you. It is good to see you again. We will be delighted to receive your testimony this afternoon. Your statements will be made a part of the record in full.

STATEMENTS OF WILLIAM J. HAGOOD, JR., M.D., PRESIDENT, MEDICAL SOCIETY OF VIRGINIA; O. RAY HURST, PRESIDENT, TEXAS HOSPITAL ASSOCIATION; AND LOUIS E. GIBSON, M.D., CHAIRMAN, TEXAS STATEWIDE HEALTH COORDINATING COUNCIL

Dr. HAGOOD. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today in response to your request for testimony to H.R. 10460 and the Health Planning and Resources Development Act of 1974. I appreciate the opportunity to tell you of the experiences of people in Virginia and their doctors in trying to work within the framework of health planning you gave us.

There are many problems. I have seen them in my job as president of the Medical Society of Virginia, as a member of the Halifax County board of supervisors and as a concerned citizen who has gone to meetings of our local subarea council and other HSA's throughout our Commonwealth. We hope the proposed amendments [see p. 709] will solve many of those problems and in a number of instances they do.

I commend the subcommittee on its work so far. However, I believe there are areas which cause major problems. We have addressed most of those in the technical report we are submitting to the subcommittee.

In this report we make specific recommendations for consideration in your efforts to correct the defects of the health planning act as it was written, as you are proposing to amend it, and as it is being implemented in our communities.

There are four general areas I will address as concisely as possible, Mr. Chairman. One, the attitude of many Virginia doctors toward the health planning work underway. Two, some problems encountered by all groups in the community who are trying to achieve goals of

the legislation. Three, comments on proposed changes to Public Law 93-641. Four, suggestions for additional changes to the act which we believe would aid communities in improving health care resources in a rational, common sense and cost effective manner.

Mistakes are being made. We believe they could and should be avoided in the future. First, doctors and other health care professionals in Virginia recognize there are problems in the present delivery system. We are working on an individual basis and as groups to try to correct those which are under our control.

We are moving methodically but positively ahead in cost containment, risk management, education and many other areas. We are taking part in health planning activities with the backing and encouragement of our professional organizations. We believe that we must take a responsible role in planning, just as we feel that we have the primary responsibility for delivering high quality care to patients.

However, in many instances we have been frustrated. We wholeheartedly agree with Congress in its belief that local people should firsthand and then shape their own local health care system into one that best serves their own and their neighbors' unique needs. Unfortunately, experience has been local HSA agencies are forced, under the threat of losing funds, to rush into hasty decisions. They are forced to draw plans from incomplete, often inaccurate or inappropriate information—for the sake of meeting a deadline.

In turn these same time constraints prevent doctors and the public from carrying on thorough reviews of extremely important plans or participating in the decision making process. We are simply not being given enough time, either, to point out the serious impact such plans and decisions could have on the quality of medical care in our communities.

Further, the scope and responsibilities of the HSA's must be more clearly spelled out. In Virginia we are seeing HSA's addressing the issue of quality of medical care assessment. This is an area in which HSA's have neither the staff capability to function knowledgeably nor the responsibility mandated to them by Congress.

My statement is partially based on the recent experiences in northern Virginia. That HSA's systems plan was one of the first in the country. Because it was rushed, that plan, despite hard working committees and task forces, was found to be seriously deficient by doctors and by almost everyone who was given the opportunity to scrutinize it.

The HSA had to be forced, because of public outcry, to provide more time. Basically, the document failed to address real medical care problems and issues. Now it is being rewritten. The redraft has substantive changes in its content and more than 100 specific changes.

Central Virginia, ladies and gentlemen, is another example. The medical society had only 8 days to review the draft annual implementation plan. I doubt that any other interested group had much more time. I submit that is not enough time to develop a thoughtful response on such a serious matter. That situation was more urgent than the one we encountered in the national guidelines.

Another point is that many people who will be profoundly affected by these plans are not yet aware they exist. Not just the general

public, but people who were involved in such areas as juvenile corrections, environmental quality and rehabilitation.

Third, I will quickly highlight our technical report. We hope the subcommittee will consider the recommendations it contains. It explains our concerns with proposed amendments, particularly those dealing with national guidelines, certificate of need, and decertification of health care facilities.

Briefly, we feel that HSA's, SHCC's, SHPDA's, are being given too much to do too soon. They have not yet demonstrated they completely understand our complex delivery system and its interrelationships. Nor do we feel they can hope to do so unless major changes are made in choice and makeup of their boards, committees and councils.

Further, unless such changes are legislated, HSA cannot measure how much programs will cost either in terms of dollars or in impact on quality and availability. Despite hard work being done by volunteers and staff, we believe their present structure does not allow them to attempt such serious undertakings.

Fourth, we request the subcommittee to address itself additionally to the following areas: methods and powers of subarea councils; relationships between agency staffs and boards, PSRO–HSA relationships; and ways to help the public become more knowledgeable and involved in the planning process.

These and other changes are detailed in our report.

Ladies and gentlemen, the problems are very real. The concern of the medical community and its desire to become more involved in health planning are real. We trust the work of this subcommittee will result in both doctors and patients getting real tools to begin to solve these problems.

Thank you, sir.

[Testimony resumes on p. 722.]

[The proposed amendments follow:]

REVIEW OF THE PROPOSED HEALTH PLANNING AMENDMENTS OF 1978

Submitted by

THE MEDICAL SOCIETY OF VIRGINIA

INTRODUCTION

The Medical Society of Virginia has completed its review of the proposed Health Planning Amendments of 1978 which are now being considered by the Subcommittee on Public Health and Environments. This review addresses relevant sections of the proposed amendment in terms of: Society support, suggested revisions and explanation of sections which will affect the capacity of health systems agencies, state health planning and development agencies, and Statewide Health Coordinating Councils to plan effectively. These suggested revisions, additions, and deletions are based upon the Virginia experience, but are applicable to all states.

This report also addresses the need for subarea councils which has not been included in the proposed Amendments. The importance of meaningful consumer and provider representation in health resource decisions has lead to this addition. The suggestions and recommendation which follow are presented in the spirit of constructive criticism. They reflect a concern shared by all members of the medical community - namely, the need to maintain the highest level of medical care which all citizens deserve.

Sec. 201 Revision and Reporting the National Guidelines for Health Planning

An annual review of the National Guidelines for Health Planning would improve the validity and subsequent reliability of the goals and standards affecting the supply, distribution, and organization of health resources. The requirement for an annual review in this proposed amendment to Section 1501 of the Act could be supported by the Medical Society of Virginia. However, the proposed amendment should be expanded to address general methodological and procedural review requirements to be implemented and disclosed by the Secretary of the Department of Health, Education, and Welfare. These review requirements are discussed in the following paragraphs.

The methodology to be used in the review of the National Guidelines to revise goals and standards should be further addressed in the proposed amendment. It appears that such review and revision will rely primarily on "a review of the health systems plans and annual implementation plans of health systems agencies and State health plans." Such reviews and revisions must go beyond that of the aforementioned plans since they often contain serious methodological, conceptual and technical deficiencies. For example, a review of published HSA plans in Virginia has evidenced deficiencies in the data base and analysis conducted to support goals, objectives, and priority actions.

Specifically, the HSA's continually point to the lack of reliable data but proceed to mandate area-wide moratoria which could adversely effect the quality of medical care. Area-wide changes in occupanc rates, lengths of stay, utilization rates, and

other health devices are proposed by the HSA to control costs and thus improve the "quality of health care delivery." While cost containment has long been supported and pursued by the Medical Society of Virginia, the impact of such cost containment efforts is often minimized in the HSA plans.

The Secretary may be aware of this problem in some of the currently published health systems and annual implementation plans from other parts of the country. Therefore, there should be legislative assurances that the extensive resources of H.E.W. will be used by the Secretary to conduct this critical task of review and revision. Similarly, a legislative requirement for disclosure of the methodology employed to review goals and standards would further promote the credibility and acceptance of the National Guidelines by the provider and consumer community.

The procedural review of proposed revisions should extend beyond the promulgation of revisions and publication of a statement of the relationship of standards and goals and the status of national health resources. While the aforementioned activities should be retained in the proposed amendment, they are prospective actions. The reliability, credibility and concurrent acceptance of national guidelines could be fostered by retrospective action.

Specifically, it should be legislated that the procedure used by the Secretary to revise and finalize the goals and standards require the input of individuals who are currently involved in the delivery of medical services. These individuals would include physicians and other practitioners who face the daily task of providing good medical care to the public. Thus, the Medical Society of Virginia urges the inclusion of a provision which would require the Secretary to involve those responsible for direct delivery of medical services in the drafting of revisions prior to publication of the National Guidelines for Health Planning.

Sec 202 National Health Priorities

The discontinuance of duplicative and unneeded services and facilities is one of the priorities which must be pursued by the medical community. However, as further discussed in a later section (Appropriateness Review), the planning agency community is neither prepared nor capable of pursuing this proposed addition to the National Health Priorities, at this time.

It appears that the SHPDA would be authorized to immediately pursue the proposed National Priority of Discontinuance. This is evidenced by a proposed provision cited in Section 221 of the Amendment. Specifically, the SHPDA is authorized to implement decertification actions within four years from adoption of the amendments. Although such action would require an amendment to the Virginia Certificate of Public Need Act, it seems that the SHPDA could conceivably implement the decertification authority through its Designated Planning Agency (1122 Program) Agreement.

The SHPDA, either through its DPA Agreement and/or its applicable state certificate of need legislation, would be required to conduct appropriateness review in conformance with approved health plans which provide the basis for certificate of need decisions. These approved health plans would include the reviewed HSA health systems plans which are used to prepare the State medical facilities plan. The HSP's, as indicated previously, require substantial revisions which may require legislated changes in the methods and approaches to plan development procedures.

The quality of the Virginia Health Systems Plans does not evidence a capacity on the part of the planning agency community to justify and document proposed planning actions which adequately consider the impact of such actions upon the quality of medical care. The expansion of SHPDA and, in turn, HSA authority to include pursuit of the national health priority of discontinuance is not advisable at this time.

The need to consider the impact of planning agency actions upon the quality of medical care has been repeatedly referenced in this report. The health planning agency community has equated Congressional findings cited in P.L. 93-641 (Section 2)

with a broad mandate to control costs without sufficient regard for quality of care impact. In some instances, the HSA's in Virginia have attempted to assume the role of professional standards review organizations in order to "tie in" cost containment and quality of care. Such attempts not only conflict with P.L. 92-603 (PSRO legislation) in terms of the authority vested in PSRO's, but have also evidenced methodological, conceptual, and technical deficiencies in the HSA's attempt to develop standards and criteria related to the appropriateness of direct medical services rendered to patients. Thus, we urge a modification and expansion to Section 1502. Specifically, the following change to Section 1502(6) cited under "National Health Priorities" is suggested:

Sec.1502(6) The promotion of activities identified by Professional Standards Review Organizations under Part B of Title XI of the Social Security Act and, State Medical Societies, and other direct providers of medical services to achieve needed improvements in the quality of medical services specified by the PSRO, State Medical Societies, and other direct providers of medical services.

Sec. 109 Membership Requirements

There are only a handful of practicing physicians among the more than 150 persons serving on the five HSA governing bodies in Virginia. This serious lack of physician-provider representation is a direct result of inadequate specification of membership (composition) requirements. In P.L. 93-641, the under representation of medical providers on the HSA governing bodies is in direct conflict with the intent of Congress and can only be corrected through major changes in the Act.

There are six Congressional findings cited in P.L. 93-641 which constitute the purpose for passage of the Health Planning and Resources Development Act of 1974 (Section 2). One of the Congressional findings recognized the importance of including health care providers in the development of health policy at the National, state, and local (health service area) levels. Specifically, the Congress recognizes that "the health care provider is one of the most important participants in any health care system...

(and thus) health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results (Section 2(6). Congress concluded that it is "imperative that the provider be encouraged to play an active role..." in the implementation of P.L. 93-641. This active role cannot be achieved by providers unless changes are made in HSA and SHCC "Composition" requirements cited in the Act.

The proposed Amendment to Membership Requirements should be expanded. The term "direct provider" should be re-defined to assure adequate medical provider representation in the HSA and SHCC (Section 1531 (3)(A). This new definition would be included in the HSA and SHCC composition requirements to achieve equitable medical provider involvement to conform to the intent of Congress (Section 1512(3)(c) (ii) and Section 1524 (b)(i)(C)).

The direct provider would be defined as those licensed individuals whose primary current activity is the provision of medical care to patients. All other licensed or certified individuals engaged in the delivery or administration of health care services would be included in the indirect provider category. The indirect provider definition would also encompass the fiduciary interest provisions and the proposed amended change to Section 1531 (3)(b)(iii) which appears on page 12 of the Health Planning Amendments of 1978 (lines 20-22).

The inclusion of Veterans' Administration and/or qualified health maintenance organization representatives on the HSA governing body and SHCC is intended to assure adequate representation by Federally funded health care organizations. This same concern for representation should be extended to the federally designated Professional Standards Review Organization. In fact, the PSRO is one of the principal entities which HSAs must coordinate their activities with as specified in Section 1513(d). This mandated relationship, in Virginia, has been consumated in one instance through an HSA-PSRO memorandum of understanding encompassing required review of the HSP and AIP. However, the inclusion of an exofficio voting PSRO representative in the HSA and SHCC organizations would strengthen the intent of the act.

The proposed redesignated subclause pertaining to the inclusion of "representatives of public and private agencies in the area concerned with health" is unclear in terms of its intent. The broad language could be subject to broad interpretation and confusion. It seems that the intent of the redesignated subclause involves inclusion of such organizations as county health departments, local medical societies, hospital associations, mental health and mental retardation organizations, and other entities concerned with the health status of health service area residents. The Medical Society of Virginia requests that such clarification be provided prior to the adoption of the redesignated clause.

Sec. 210 Governing Body Selection

The proposed amendment pertaining to the disclosure of governing body selection methods should be expanded to include disclosure of the methods used to select the executive committee, other members of standing committees, and selection/election of governing body members. Such disclosure should include publication of the method used to appoint, select, or elect members, the procedures used to review member qualifications (in terms of Composition requirements cited in Section 1512(b)(3)(c), the manner in which terms of office are decided, the process used to fill vacancies, and the procedures which specify the manner in which members may be removed from office. The aforementioned elements constitute the basis for determing whether there is, in fact, the opportunity for broad participation by residents in the Health Service Area. A preliminary review of Virginia HSA By-laws evidences a tendency for HSA's to engage in legalistic language which is difficult to review in terms of evaluating the adequacy of consumer and provider participation in the HSA structure. Thus, the requirement for full disclosure may enable residents to fully understand how and why members are selected to serve on the HSA.

Sec. 212 Meetings and Records

The Medical Society of Virginia is currently conducting a survey of scheduled HSA, SHCC, and SHPDA activities. This survey includes the identification of the nature, scope, and location of governing body, council, and standing committee meetings. The preliminary results of the survey evidence an immediate need for passage and expansion of the proposed section amendment.

All HSA's, SHPDA's, and SHCC's should be required to not only conduct their meetings in public with adequate notice, but should also be required to publish a list of their scheduled governing body, executive committee, standing committees, and council meetings as a matter of routine. Request by the public of such meetings assumes that the public is aware of planning agency activities. The Medical Society of Virginia believes that the planning agencies have an obligation to their service area residents which requires routine disclosure of meeting dates, purposes, and activities. Thus, the HSA's, the SHCC, and the SHPDA should be required to give at least 30 days notice of its meetings in at least two (2) newspapers of record without the necessity of a specific request from residents.

Sec. 214 Conflict of Interest

The majority of HSA's in Virginia have adopted conflict of interest provisions in their by-laws as a result of PHS. Region III policy requirements. These provisions are currently part of the ongoing operating procedures of Virginia HSAs that are used prior to project review deliberations. The Medical Society of Virginia could support a national requirement for all HSAs and SHCCs to include conflict of interest declaratives which must proceed all HSA and SHCC deliberations and actions. However, the proposed amendment could prevent providers from voting and/or participating in any health care issue. For example, physician affiliation with hospitals (i.e., staff privileges) could be considered a "consultative relationship." Similarly, the term "fiduciary" not only encompasses financial but also professional interest and involvement with health

care organizations. The term "substantial" would require similar clarification since it could be defined in view of financial renumeration, hours of employment, or position on an advisory board of an organization.

Sec. 216 Health Plan Requirements

The Medical Society of Virginia could endorse the provision requiring the inclusion of an agency work statement as an integral part of the HSP and AIP. This statement, however, should be prepared as a comprehensive document which specifies the work activities and concurrent work assignments to be undertaken by the HSA to achieve goals, objectives, and priority actions.

The Medical Society of Virginia also could endorse and support the provision for a public hearing on the AIP. However, the provision should be expanded. During the public hearings on the HSPs, it became evident that many of the HSAs had failed to provide adequate time for interested parties to obtain and review the draft plans. The HSAs met the letter of the law but due to a variety of reasons failed to allow adequate time for detailed review of draft plans. Thus, we would urge expansion of the proposed amendment. The HSA should be required to publish its notice of a public hearing at least 60 days prior to such hearing. This provision would be applicable to the HSP, AIP, and State Health Plan produced by the SHCC. Similarly, the HSA, SHPDA, and SHCC would be required to expedite distribution of their plans so that a minimum of 60 days would be provided for interested individuals and organizations to review and comment on proposed plans.

Sec. 224 SHCC Composition and Sec. 217 Criteria and Procedures for Review

The Medical Society of Virginia could endorse and support the proposed amendment changes. These changes will assure that the state-wide plan development process will be carried out through the SHCC membership. This membership will be selected by an elected official (the governor) who represents the voice of the public at large.

Sec. 218 Certificate of Need Programs

The proposed amendment cites some positive elements which could be supported by the Medical Society of Virginia. These include provisions for:

- an annual review of progress made in completing approved certificate of need projects;
- specifying a maximum amount of expenditures in the certificate of need approval (with adequate justification and documentation supported by recognized professionals in the construction and health facility development field); and
- the publication of regulations to assure conformity to a national certificate of need program (in accordance with the process described in the review and development of National Health Priorities).

However, the proposed addition to Part C - State Health Planning and Development - for an expanded Certificate of Need Program would not be supported by the Medical Society of Virginia at this time. The expansion of certificate of need authority to include "appropriateness review" and "decertification" is the principal reason for such opposition. While appropriateness review and decertification are not specifically cited in this proposed amendment, the activities of review and discontinuance of health facilities and services (decertification) are intimately tied to certificate of need actions. For example, Section 218 of the proposed Health Planning Amendments of 1978 requires each certificate of need decision to be consistent with the state health plan. The state health plan includes the findings resulting from appropriateness review to all institutional health services conducted by the HSAs. This review is to constitute the basis for a determination of the institutional services which are to be discontinued. Thus, the intimate relationship which must exist between health planning efforts and certificate of need decisions is based upon the validity and credibility of the technical procedures used to collect and analyze health data.

The HSAs have not evidenced this technical capacity in their health plans. Hence, the expansion of certificate of need authority is premature. The HSAs have not documented their ability to consider the impact of their activities upon health care quality. The SHPDAs have not even begun to review HSA plans and, given the deficiencies in the composition of HSA governing bodies, would not have adequate representation on the SHCC to review and monitor SHPDA certificate of need actions through plan development efforts.

Sec. 219 Appropriateness Review

The proposed amendment to Section 1523 (2)(6) of the Act references the Secretary's authority to designate certain institutional health services which will be subject to "Appropriateness Review." However, there is no indication of the manner, procedure, or process which will be used by the Secretary to accomplish the task of designation. It can only be assumed that such designation will be based upon the findings cited in HSA plans. These findings may be misleading and may not reflect the complex impact of decertification activities upon the medical care delivery system.

It seems that the HSA and SHPDA would be authorized to immediately undertake decertification action. Specifically, within four years of enactment of the Health Planning Amendments of 1978, the SHPDA will have declared a state-wide moratorium of those institutional services found to be inappropriate (p. 27 lines 10-17). In essence, the Secretary will be the individual responsible for initial decisions regarding the health care services which may be inappropriate. This action conflicts with the basic purpose of P.L. 93-641--specifically, the creation of a system of state and local health planning agencies responsive to its constituency and responsible for decisions arrived from local study and analysis.

The HSAs, the SHCC and SHPDA with adequate representation from its consumer and provider constituency should make such decisions. Unfortunately, the community of planning agencies have not reached this point of independent decision making. However, with equitable adjustments in legislation and continued dedication to the technical validity of its decisions, the planning agency community should not be deprived of the right to reach its own conclusions. Thus, Appropriateness designation should for the time being remain the prerogative of the planning agency community.

Sec. 221 Coordination of Health Planning with Rate Review and Sec. 222 Coordination within SMSAs

The requirements for coordination of HSA and SHPDA activities cited in Sections 221 and 222 are fully supported by the Medical Society of Virginia. However, similar coordination requirements should be developed for HSA and SHPDA interaction with major providers of medical care. Such coordination is required to increase the validity and reliability of HSA plans and associated activities. The HSA would, in conjunction with medical care provider organizations such as the Medical Society of Virginia, prepare a plan approved by the Secretary which would provide, at a minimum, the review of HSPs and AIPs. This same provision would be associated with SHPDA plan development activities.

Subarea Advisory Councils

The need for establishment of subarea advisory councils should be reflected in the proposed Health Planning Amendment of 1978. Many HSAs have decided against the formation of such councils due to the costs required to support subarea planning efforts. In fact, the current provision in P.L. 93-641 allows for flexibility. The HSA is allowed to independently decide whether "grass roots input" is worth "the cost." However, grass roots involvement in the decision-making process is necessary if planning is to truly reflect the needs and demands of the community.

Obviously, the opportunity to serve in a meaningful capacity on the HSA decreases when the size of the governing body is kept to a minimum. The degree of flexibility allowed in decisions regarding the formation of subarea councils should be dependent upon ths size of the governing body and the geographic area included in the health service area. Thus, we would urge the adoption of an amendment to Section 1512(6)(c) - Subarea Councils. This amendment would require the establishment of subarea advisory councils representing parts of the agencies' health service area when the size of the governing body was less than 30 members. This provision would assure adequate community representation in the planning process.

The responsibility and role of the subarea advisory council is currently restricted to an advisory function. This role should be expanded. It could be expanded through the requirement that the elected chairperson of each subarea council should be included as a voting member of the HSA governing body. Similarly, a legislated requirement similar to the language used to resolve conflict between HSA recommendations and SHPDA actions could be proscribed to strengthen the subarea council advisory role. For example, a new clause would be added to the subarea council subsection which would require the HSA to justify nonconforming actions to the SHPDA. At the same time, the subarea council would be provided with an appeals provision entitling its membership to a fair hearing at the SHPDA and SHCC levels. Such revisions should be included in the proposed amendments to P.L. 93-641.

Mr. ROGERS. Thank you very much.

There is a call to the floor for a vote. So we will stand in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order please. We are continuing our hearings on planning.

Now, for the Texas Hospital Association.

STATEMENT OF O. RAY HURST

Mr. HURST. Thank you, Mr. Chairman. I appreciate the opportunity to be here.

My name is Ray Hurst, president of the Texas Hospital Association. My comments are intended to be constructive and to be supportive of testimony that will be presented within the next day or two by the American Hospital Association, also, just in a few minutes by Dr. Louis Gibson.

The Texas Hospital Association is an organization of about 600 hospitals. Many of them are small, many are rural ones, and of course there are large metropolitan centers also. We have been very supportive over the years of comprehensive health planning. I think you know that.

We have been active in implementing the existing law in the State. We passed local legislation within about 6 months after Pub. L. 93–641 was initially passed. We hope that you understand that when we speak for a membership organization we do not speak for every one of them, but overall our membership is supportive of the planning effort.

We recognize the need and wisdom for it. We certainly want to see a reasonable implementation of the law. Our support in the past has been based on the theory that the best determination is local determination.

Certainly we understand that the State needs to be involved and at some point in time the Federal Government has to be involved also.

We do register opposition, however, to any proposed change that would take away from serious consideration for the needs of the people as determined at the local level. We think that is an extremely important point to be made here. Certainly local resource allocation, I think, is a major point in my testimony.

Originally, I think, it was the belief that planning would be of assistance in resolving this problem of endless demand for health care facilities and especially hospitals. In our view, if given just a little bit more time I think this is coming to pass.

Our certificate-of-need law is working very effectively. The bulge that we saw when the law was first passed 3 years ago is gone now. The Health Facilities Commission is in good, firm control and operations, and we would like to see that local determination through the HSAs, through the SHPDA or SHCC and on to the certificate-of-need agency to be carried out.

Certainly we recognize that health care costs have increased. Certainly we recognize that hospital costs have increased. I think the

committee would like to know and I believe we furnished you separately, not in connection with this testimony, but some of the effective work we have already done in Texas and other surrounding States in containing health care costs.

I would hope that the example that we cited in our testimony, that I would not detail at this point, will be looked at.

Also, with regard to judgment factors about economically productive people and nonproductive people and how they have been treated in some other countries. I would hope that the committee would not consider that necessary in these United States.

We do have some problems with the implementation of the existing law with regard to the guidelines that have been published under both titles 15 and 16, Mr. Chairman and members of the committee. We have done some studies of some Congressional districts with regard to the full effect of those two guidelines if fully implemented. It was not part of my original testimony, but if you would like to have it we would be glad to share it with you.

We did it for four congressional districts and the HSA's that made up those congressional districts. It is a little eye opening. In one of the districts, Mr. Burleson's, for example, they would have to close almost 4,000 beds, just in one congressional district, in order to meet the guidelines.

There is an interlock between those regulations that deals with titles 15 and 16 of the existing law. I wanted to be sure that you had a note of that.

We hope that this legislation and the resolution of the proposed changes to the legislation can be promptly handled, that a meat axe, if you please, is not taken to the bill, and that we be given some more time to adequately implement what is already on the books.

We think the basis for the legislation is quite good and I commend you for your foresight, Mr. Chairman, you and the members of your committee who put it together initially, because it was far-reaching. We would strongly urge that when the committee and the law says guidelines that you be sure to tell the Secretary of HEW that you are talking about guidelines and not flat standards.

Thank you very much, sir.

[Mr. Hurst's prepared statement and attachment follow:]

Statement of the Texas Hospital Association
Before the
Interstate & Foreign Commerce Health Subcommittee
February 1, 1978

Mr. Chairman, I am O. Ray Hurst, President of the Texas Hospital Association, which includes both rural and metropolitan hospitals. Our organization has in the past supported comprehensive health care planning and was active both at the state and national level in this support.

As you are aware, there was not in the past, and is not now, wholehearted support for this activity but I am here to speak in the support of the renewal of P.L. 93-641 and am most appreciative of your courtesy in allowing us to be heard.

Our support in the past has been based on the theory of local determination as expressed in locally developed plans. Currently the debate centers around whether the planning process will remain an essentially local and state mechanism of resource allocation or become a federally controlled regulatory system. We oppose the changing of the basic concept of the program to one of federally imposed regulations at the expense of local planning. Although many points could be covered, local resource allocation is the major point of my testimony.

Originally it was thought that planning would be of assistance to resolving the problem of an almost endless demand for health care with hospitals bearing the brunt of the increased demand. Increased types of patients such as short term psychiatric, patients suffering from drug abuse, alcohol abuse and patients requiring treatment heretofore unknown were admitted to hospitals in larger numbers. In this activity the hospital acted as the consumer advocate in attempting to meet this demand. The net results were two:

1. Hospital costs rose in direct response to the recognized public need for access and quality of care causing questions concerning how much should be spent on health care.

2. Hospitals were accused of empire building and their medical staffs pictured as groups demanding the very latest equipment for the purpose of self-aggrandizement.

We viewed planning as a means of expanding the base of local input in assisting with these medical requirements which had assumed major social and economic significance requiring carefully thought out solutions with due care for local requirements and, above all, avoiding formulas that had limited or fallacious bases. This general concept was the basis for P.L. 93-641. However, in the implementation of P.L. 93-641 local and state plans must conform closely, if not absolutely, to national planning guidelines which, in turn, already have been issued as rigid formulas--formulas that if allowed to prevail will ration health care to the extent of refusing admission, in some states, to every fourth prospective patient. Authority for enforcement of these guidelines, although not specifically given by Congress, can easily be accomplished by denial of funds to Health Services Agencies who do not conform--as well as other sanctions.

These desperation attempts to force local compliance to rigid guidelines stem from either a desire for power or a more generalized and understandable reason--the

federal government is both a purchaser of services and a regulator of the prices paid for this service. This does place the government in a difficult situation but a balance must be established. In this we are not without precedent from which a valuable lesson could be learned.

For example, some theorists have long maintained that the demand for health care is endless and a rational system would divide patients into three categories:

a. Economically productive
b. Economically unproductive
c. Economically benign

The economically productive would be those that are currently working thereby contributing to the economic good, the economically nonproductive as represented by older, perhaps retired, and the benign those patients requesting treatment not closely related to economics such as certain types of plastic surgery. The theory is that maximum care be given to the economic productive and if any be left over, then this could be distributed to other categories. I do not subscribe to this theory but under a centralized system, with minimum input from local areas, it may and has occurred. For example, about ten years ago there appeared in the press an incident in England where it was discovered a notice had been published that gave instructions to allow a patient seeking admission and exhibiting certain symptoms to expire instead of rendering treatment. After publication of this story the sign was removed. Some say that this could not happen in this country. However, I would like to call your attention to the recently issued guidelines pertaining to Title 16 of the PHS Act--a companion of the guidelines pertaining to Title 15.

This guideline limits, as a maximum, the number of allowable patient days to 1,000 per 1,000 population. By interlocking with other formulas the limit is further reduced. Currently the national average number of hospital days used per 1,000 population is 1,209. In Texas, this would dictate the refusing of admission to every fourth patient. This represents a flagrant example of the use of rigid formulas--formulas which could, perhaps, be applied to a young age group of people, relatively affluent and passing a required physical examination before admittance to the group--but not the general public.

Our presentation has been a plea to build safeguards into this law to prevent capricious and ill considered schemes to stifle local initiative. While the difficult situation faced by those that are placed in a conflict of interest position by being both a purchaser of care and a regulator of price is understood, a balance must and can be achieved.

Resolution must be rapid and must not be allowed to degenerate into bureaucratic wrangles such as those surrounding HSA designations that have not only been expensive but to date the rigidity of the system also has allowed only 9 of the 205 Health Systems Agencies to be fully designated--this after three years.

We request that the law continue to be based on local determination as expressed in locally developed plans and the formula requirements, as they have proven to be inoperative, be deleted. We believe this to be workable as most of the personnel connected at the federal level with planning are known to us by reputation at least and we believe them to be able to accomplish the Congress' desires if properly led.

ORH/sae/lb/1/25/78

F-1

THA
TEXAS HOSPITAL ASSOCIATION 6225 U.S. Highway 290 East - Mailing Address: P.O. Box 15587, Austin, Texas 78761 — A.C. 512-453-7204

January 30, 1978

Mr. Bob Crane, Staff Counsel
Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Crane:

Enclosed please find copies of a letter dated January 26, 1978 addressed to Henry Foley, Ph.D., Administrator, Health Resources Administration, in which the Texas Hospital Association provides comments concerning the Revised National Guidelines for Health Planning as published in the Federal Register on January 20, 1978.

We request that this letter be included as a part of my testimony previously submitted on the Statement of the Texas Hospital Association to be presented before the Subcommittee on Health and the Environment scheduled for February 1, 1978.

Sincerely,

O. Ray Hurst, CAE
President

sjr
Enclosures

THA
TEXAS HOSPITAL ASSOCIATION 6225 U.S. Highway 290 East — Mailing Address: P.O. Box 15587, Austin, Texas 78761 — A.C. 512-453-7204

January 26, 1978

Henry Foley, Ph.D.
Administrator
Health Resources Administration
Center Building, Room 1022
3700 East-West Highway
Hyattsville, Maryland 20782

Dear Doctor Foley:

On behalf of its almost 600 member hospitals, the Texas Hospital Association is pleased to respond to your request for comments concerning the Revised National Guidelines for Health Planning as published in the Federal Register on January 20, 1978.

In our letter to the Secretary of Health, Education and Welfare of December 7, 1977 concerning the Proposed Guidelines for Health Planning published in the Federal Register on September 23, 1977, we expressed concern with a number of problems with regard to the proposed document. We are encouraged by some of the revisions made as we find them to be steps in the right direction.

As expressed previously, we are however concerned with the failure of the Department to separate its continued insistence on awkward and unworkable cost controls from the primary intent of P.L. 93-641, that being planning. Further, we are disturbed that the Secretary persists in trying to reduce cost and improve quality by edict and arbitrary quantitative standards. In our opinion, neither cost control nor quality can be effectively mandated by the Secretary.

Although we note an improvement in the "tone" of the guidelines and changes with real potential in a number of areas, we see no material change in their intent. For example, although the guidelines appear to contain major adjustments by HEW, a careful assessment reveals that most of this is only illusionary. This is revealed through the clarification of the intent of HEW to provide for assessment of the need for exceptions by the local health systems agency. This body is to submit its findings to the SHPDA and SHCC, however, final authority to overrule such an adjustment still remains in the hands of the Secretary in that he will receive a report on exceptions from the SHCC and he controls the redesignation and funding process. (The implication is that the Secretary intends to take advantage of this and to maintain a centralized approval mechanism in Washington to control the activities of all health care facilities in the country, despite protestations to the contrary.)

Texas Hospitals: Official Monthly Journal
Affiliates: Texas Hospital Education and Research Foundation, and Texas Hospital Association Health Services Corporation

Although the statement of intent to eliminate funding to an HSA which does not "conform" has been removed and the term "consistent with" has been defined, it remains clear that an HSA must conform within five years, even though it has no authority under law to bring about conformance. Otherwise, the HSA may not be redesignated or refunded.

A review of the annual occupancy rate standard which exempts rural hospitals with less than 4000 admissions, when justified by the HSA, reveals that most Texas HSA's do not have adequate resources to do the present job, much less develop necessary detailed justifications for exceptions. Staff time and financial resources can be better utilized in a real effort at system improvement. Viewing the occupancy standard closely from a system perspective, it is clear that whether rural hospitals are exempted or not, the overall 80% occupancy for the HSA will have to now be carried by the metropolitan hospitals.

Rural hospitals would also appear to be exempted from the minimum utilization standards for obstetrical services assuming that all provide only primary care or uncomplicated delivery services. This is simply not the case. Many hospitals in non-metropolitan areas provide care of the type described in the document as Level II services. Further, neonatal intensive care services are also available and much needed in non-metropolitan areas. In our view it will be extremely difficult if not impossible for hospitals in non-metropolitan areas to justify an exemption from this standard. As a result, patients currently being served near their homes will have to travel many miles for the same care at a greatly increased total cost.

In viewing the exceptions granted, one must only reflect on the "exception process" available to hospitals in other programs carried out by HEW to know that such exceptions are rare. (In fact, it might be said that the publicity on the issuance of these revisions is an attempt to deceive the public into believing that the exemptions will be the norm particularly for rural areas, when such may not be the case.)

The revisions also contain a number of inconsistencies. One such example is the statement that HSA's should use "licensed beds" within an area as the basis for determinations. The recently published Guidelines for the Development of State Medical Facilities Plans and all available material on grants programs for facility development utilize "survey capacity". This is an inconsistency of critical significance.

Many HSA's in areas of the United States which are already more heavily regulated have come to view themselves as "regulators" and "enforcers". This is not the intent of P.L. 93-641 in our opinion. The law calls for a cooperative planning process at the local level. We have much difficulty finding this intent in the guidelines as revised with their overriding emphasis on cost control.

In reviewing national standards such as 4 beds/1000 population, we recognize that there must be a starting place, however, we question the justification for ceilingswhich do not reflect the diversity of our state where the length

of stay and cost per day of care is significantly lower than the national average. We would therefore urge that these ceilings be changed to target rates and that studies be undertaken to identify realistic, specific target rates for specific regions of the United States.

Proposed regionalization based on level of care rendered would be detrimental to Texas physicians, hospitals and patients residing in non-metropolitan areas. Where distances between facilities are great, community pride and confidence in its hospital should not be lessened by arbitrary categorization which has a derogtory connotation, although perhaps not intended. In other words, in the eyes of the public, level and quality are synonomous.

We appreciate the consideration the Department gave to the special problems encountered by hospitals with specialized services such as open heart surgery, cardiac catheterization units, and computed tomography. However, the fact remains that the addition of a requirement that HSA's take all scanners in the area into consideration, regardless of location, ownership (some of which are not subject to the law), or scanner capacity, before considering new scanners and the fact that there are no exceptions to the standard for new cardiac catheterization units, which prohibits such unless the facility also performs open heart surgery, further reveals the Department's unbending approach in areas where there are few absolutes.

Of major importance is the fact that we, along with the Governor, and other Texas health care professionals, visited personally with the highest level officials of HEW to express concern over the September 23 proposed guidelines. We were well received and our ideas attentively heard. We were promised that our consultation and assistance would be requested in subsequent revisions. No such assistance was requested of us, and our first indication that the latest revisions had been made came when we learned of the Secretary's pending press conference. We consider the action taken by the Department a breach of faith.

We again call for the withdrawal of these guidelines and the development of realistic approaches to the planning and cost control directives of P.L. 93-641 based upon studies to be undertaken immediately utilizing available information and technology in order to carry out the intent of Congress. Or, as a minimum, the regulations should clearly and succinctly delineate these "guidelines" as bench marks or targets for planning with final authority for compliance vested with local and state officials.

Sincerely,

O. Ray Hurst, CAE
President

ORH/cer/sjr
cc: The Honorable Dolph Briscoe, Governor of Texas
Joseph A. Califano, Jr., Secretary, Department of Health, Education and Welfare
Texas Congressional Delegation
Office of Planning, Evaluation and Legislation
Health Resources Administration

Mr. ROGERS. Thank you very much, Mr. Hurst. I think we have told the Secretary that guidelines are guidelines and they are not directives. I think the Department understands that now.

Mr. HURST. I certainly hope so.

Mr. ROGERS. Mr. Satterfield?

Mr. SATTERFIELD. Thank you, Mr. Chairman.

I would like to echo your last remark. I too hope that the Department understands that now.

I would like to ask a question of both of the gentleman who testified, Dr. Hagood first, if I may; did the Secretary of HEW or anybody in HEW consult with your organization before issuing either set of guidelines?

Dr. HAGOOD. To my knowledge, no.

Mr. HURST. Would you like to ask me the same question?

Mr. SATTERFIELD. Yes; I would.

Mr. HURST. Thank you, Congressman.

We came to Washington at the request of our Governor who was quite upset about the initial guidelines. We discussed it with the Secretary, the under-secretary, and several members of the staff. We were promised we would be consulted before the guidelines were reissued. Frankly, we were not.

I have requested that an addendum be filed to my statement which incorporates a letter that I wrote to Dr. Foley at the request of my Association. The letter outlines our continued concerns over the guidelines and expresses the hope there would be some additional changes considered. I would have to say in all sincerity that I think there will have to be congressional changes. I think there are a couple of areas of ambiguity in the wording of references between standards and guidelines that I believe the Secretary is interpreting one way when it is my sincere belief that the congressional intent was something slightly different.

Mr. SATTERFIELD. Could you identify the source of the commitment or promise that you would be consulted?

Mr. HURST. It was the under-secretary, Hale Champion and Dr. Foley.

Mr. SATTERFIELD. That is, the two gentlemen who testified here on Monday?

Mr. HURST. I was not here on Monday, Congressman.

Mr. SATTERFIELD. They did testify then. I was interested in the fact that Dr. Foley attempted to deny the testimony of Dr. Julius Richmond last year that this required consultation did not occur. He said that Dr. Richmond had been wrong and did not mean to say that. I think your testimony now is most enlightening and I appreciate it.

Mr. HURST. Mr. Satterfield, I am not the only one who heard it. The gentleman to my immediate left Dr. Gibson also heard it as did Dolph Briscoe, the Governor of the State of Texas.

Mr. SATTERFIELD. I am extremely interested to learn that fact. Thank you, sir.

Dr. Hagood, you mentioned on page 5 of your statement that certain people were not even aware that they would be given an opportunity to analyze these health systems plans. You also mentioned the fact that the Medical Society only had 8 days to review

the draft. I wonder if you can tell us how long or how voluminous the draft of the plan of the HSA of Central Virginia was?

Dr. HAGOOD. I can answer that this way, Mr. Satterfield.

With reference to the "AIP" that was issued for the central VA group, that letter was written the 15th of December. I received it the 24th of December, Christmas Eve, with instructions to respond to it by the 6th of January. Of course that time of the year is a rather unusual time of the year, so it was difficult to get this thing done.

We asked for an extension and we managed to get this thing in, I think, by the 11th of January. Then when I went to a subarea HSA meeting, the people there were given a 5-pound 1-ounce grant application for the central Virginia area and were told at the same time that "You have guidelines in which to study this and to come back and then we will vote on this thing."

I was most impressed with the reaction of the consumers there. They raised the devil.

Mr. SATTERFIELD. Do you anticipate that you will go through this exercise again now that some alternative guidelines have published?

Dr. HAGOOD. I would hope not. I would hope that we would get more time in which to do this, but we in Virginia and the Medical Society of Virginia in particular are doing all that we can.

To give you some idea of what the president is doing, in the first 6 weeks I was president I lost 5 pounds trying to run around and get something done about this thing and getting the thing going. It has consumed the major portion of my waking hours. During the other little dab of time, I managed to practice some medicine, but during the other time I was trying to keep up with this thing and to get the Medical Society of Virginia and the medical profession actively involved in this thing in Virginia.

Mr. SATTERFIELD. I was also interested in your comment that some of the people, providers, consumers and others, are not even aware of HSA's existence. I assume from your comment that you would say then that they really do not consider the matters pending before the HSA. I am wondering if this also applies to the providers of health services?

Dr. HAGOOD. Personally, I am most concerned that my profession, the average doctor, is really not aware of what has gone on and what is going on and what will go on with reference to Pub. L. 93–641. Knowing that he does not know, there is not any way that his patient will know about it either.

Again, the Medical Society of Virginia has gotten out a brochure that is intended for distribution to the public by the doctor. However, we had to include along with a copy of the brochure a letter to the doctor to try to tell him something about what HSA's are all about and at the same time to encourage him to get further supplies of the questions and answers on HSA's that we have prepared for his patients.

Mr. SATTERFIELD. I would like to ask this question: Based on your review of the work with which the HSA's that you have been involved with are concerned, do you believe that they have sufficient information and technical expertise to perform the functions required by the act?

Dr. HAGOOD. No; I do not. To go back to this subarea HSA that I went to, these people were completely bewildered. They were just at sea. I introduced myself and I gave some testimony to them. I have never been so welcomed since I came home from World War II, to come into their midst and their feeling that "Here is somebody we can turn to". I realize the tremendous plight they were in.

I took a tremendous calculated risk to say to them that "If there is any way in which the Medical Society of Virginia can help you with your orientation and can help you with these problems that you have, please ask us". Then I almost had to run out the door to get on the telephone to Craig Sealove to tell them what I had done in an effort to try to get this together. I am pleased to say now that we are about to get it together.

Mr. SATTERFIELD. Are you aware of the remarks Monday by Mr. Champion, speaking for HEW, in connection with these amendments? Have you seen his testimony?

Dr. HAGOOD. No, sir; I have not seen that.

Mr. SATTERFIELD. In the course of my questioning I asked him, in the event the cost containment legislation did not pass congress, if he felt he had the power under the act to require HSA's to perform the same function. His response was no but he anticipated that they would issue guidelines. If that were to occur, is it your opinion that HSA's would be in anyway equipped technologically or otherwise to administer such a cost containment program?

Dr. HAGOOD. I do not see how they can do it under the present circumstances.

Mr. SATTERFIELD. Would the gentleman from Texas care to respond?

Mr. HURST. There is no way and heaven help us if they are given that responsibility.

Mr. SATTERFIELD. I would like to say one thing and then I will stop talking because I know that it is late. In the remarks that were given to us Monday by the Secretary it was stated that there are several amendments to this act that are to be submitted to the Congress.

Mr. Chairman, have they been submitted yet? Do we know when they are coming?

Mr. ROGERS. Is that when their own bill would be presented?

Mr. SATTERFIELD. Yes.

Mr. ROGERS. I understood it would be presented by the end of the week.

Mr. SATTERFIELD. I think it would be extremely important that these witnesses as well as all others who have testified in these hearings be given an opportunity to comment on those specific amendments. I would ask unanimous consent that the record be kept open for that purpose so that we may consider those new amendments and the witnesses' responses to them when we mark this bill up. I would ask unanimous consent for that.

Mr. ROGERS. I have no objection to keeping the record open for any comment they believe would be helpful to the committee. I think we will have to close it in a reasonable time after the conclusion of the hearing. I would certainly think we can keep it open for a certain period of time.

Mr. SATTERFIELD. Mr. Chairman, if we are going to mark up this bill it would seem to me that the witnesses ought to have an opportunity to comment on any amendments provided by the Secretary of HEW. I would hope that we would have that opportunity and that we can consider the comments before we start marking up the bill.

Mr. ROGERS. We may not want to do what HEW asks us, Mr. Satterfield.

Mr. SATTERFIELD. It may be that the majority of this subcommittee will.

Mr. ROGERS. Of course it is their right if they desire to. I do not know that we can hold up the legislative process forever to wait for comments to come in. I think we can give them a reasonable time, 10 days after we receive the bill.

Mr. SATTERFIELD. That is all I am asking for, Mr. Chairman.

Mr. ROGERS. I think that is reasonable.

Mr. SATTERFIELD. Thank you.

Mr. ROGERS. As I understand it, Dr. Hagood, what you were saying is that you had the 8 or 9 days for the annual implementation plan not for the health service plan, the HSP?

Dr. HAGOOD. That is the first one that came out.

Mr. ROGERS. Before the HSP is approved, a 30-day notice has to be published in the paper. I presume the medical profession has providers on the HSA's, do they not?

Dr. HAGOOD. You presume what?

Mr. ROGERS. Are there not some members of your society in Virginia providers of HSA's who are drawing up the plans?

Dr. HAGOOD. Yes, in the whole State of Virginia, of the five HSA's we probably have about a dozen doctors that are on that scattered throughout the State.

Mr. ROGERS. There would be some on each of the HSA's?

Dr. HAGOOD. Yes; that is in private practice.

Mr. ROGERS. So you have an impact right from the beginning on planning, so your views, I presume, are expressed by those members, are they not?

Dr. HAGOOD. Yes, but at the same time, Mr. Chairman, five of these doctors in one HSA become so bewildered and frustrated and so inundated with the avalanche of white paper that was coming from Washington that that they finally, in trying to carry on their practice and in trying to meet deadlines, threw up their hands and resigned. I wrote quite a lengthy letter to them, thanking them for their service, asking them please to reconsider because they had some input in it, they had some knowledge. Some of these we were able to get back and some of them we have not.

Mr. ROGERS. Of course, the opportunity is there for the input?

Dr. HAGOOD. The opportunity is there, Congressman Rogers, and they are meeting the law. This is legal. But when it comes to the spirit of the thing, I question it.

For instance, any of these hearings that go on in the South Central HSA in Virginia, they will publish and print such that you need a large magnifying glass, first of all, to find the thing in the paper. It will say in there something like this, that there is to be a hearing

in 4 areas scattered throughout a 22-county area there, and that there are 8 areas in this 22-county area where the plan is being exhibited.

You are invited to go there during the hours that this office is open. Of course, this is for both providers as well as consumers, to go there and sit down and go through these tomes that weigh anywhere from 5 pounds 1 ounce, I said—I have one that is 5 pounds 6 ounces—to wade through this thing. And they can take time off from their work, if they wish to, to go into this.

It is not very likely that the public is going to do this. Certainly for a physician who is operating an office and seeing a number of patients each day this is well nigh impossible to do this. Nevertheless, the law has been met. But it has been impossible to take advantage of this opportunity.

Mr. Rogers. Of course we want everyone to have an opportunity to have an input and that is the way it was designed. In this bill on the annual implementation plan we add a requirement for 30-day notice, so you would not be caught with 8 days.

I think that is wrong. I think you do need more time. We are trying to make those changes so that you can have the opportunity to help guide the process and give suggestions.

Dr. Hagood. Actually we need to know when this is coming up so that we can contact people who are knowledgeable, who have ability to really put input of value into this, because they will have to change their schedules in order to make the meeting in some distant city, to sit down with a group of people and begin to go through this sort of thing. So that this is one of the big reasons we need a big piece of time like this in order to rearrange or to arrange schedules so that people, consumers as well as providers, can get together and meet the law.

Mr. Rogers. Of course what we have tried to do in the makeup of the HSA is to provide both provider input and consumer input so that when the plan is first developed you have all of that input right then. Then the review of the plan can take place, so all the forces can come back again and comment. So we are trying to get a double input in effect.

Dr. Hagood. This is entirely correct. As it turns out, as the time squeeze comes, the subarea HSA's throw up their hands and they turn to the staff person and say, "What should we do?" They have to accept without question what the staff person tells them.

Mr. Rogers. Yes, because the implementation plan is only a plan for 1 year and I would think that that would not be too difficult to go over. Now the 5-year plan requires more time.

Your testimony has been helpful. We will look at your suggestions.

Dr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

I notice on page 4 of your testimony, Doctor, you say HSA's are addressing the issue of quality of medical care assessment. Is this correct?

Dr. Hagood. I am sorry, Dr. Carter, but I do not quite understand your question.

Mr. Carter. Is it true that HSA's are addressing the issue of quality of medical care?

Dr. Hagood. Yes.

Mr. CARTER. They are at the present?

Mr. Chairman, is that within their purvue? On page 4 of Dr. Hagood's testimony he states HSA's are addressing the issue of quality medical care. Is that part of the duties of HSA's?

Mr. ROGERS. I think that is PSRO.

Mr. CARTER. It is my opinion too that HSA has nothing to do with that. Their job was to plan and to implement those plans.

Dr. HAGOOD. This is my understanding that the HSA provides the facilities, the PSRO studies how you are going to do it.

Mr. CARTER. The PSRO, of course, has charge of the quality control, as I understand it.

Dr. HAGOOD. Yes, sir.

Mr. CARTER. I think your HSA is exceeding its authority in that area.

Dr. HAGOOD. Yes.

Mr. CARTER. I notice on page 5 that you have concerns with amendments. What amendments concern you, sir—those having to do with guidelines? What particular amendments are you concerned with?

Dr. HAGOOD. In our technical report on page 2 these are given. The annual review of the national guidelines for health planning would improve the validity and subsequent reliability of the goals and standards affecting the supply and distribution of organizations of health resources.

The requirement for an annual review in this proposed amendment to section 1501 of the act is supported by the Medical Society of Virginia. However, the proposed amendment should be expanded to address general method logical and procedural review requirements to be implemented and disclosed by the Secretary of the Department of HEW.

Mr. ROGERS. I wonder if I could interrupt. We need to hear from Mr. Gibson. They have to make a plane—as of what time?

Mr. HURST. I have a real time problem, Mr. Chairman. If I could be excused I would be grateful to you. I will be glad to answer any questions that Dr. Carter and others have before I leave.

Mr. ROGERS. Dr. Gibson?

Dr. GIBSON. I do not have a time problem.

Mr. ROGERS. Then we will excuse you, Mr. Hurst. I hope you can make it. I hope we have not held you too long.

Mr. HURST. Thank you very much. I appreciate the opportunity.

Mr. CARTER. Are you worried by the certificate-of-need program?

Dr. HAGOOD. Am I worried about the certificate-of-need?

Mr. CARTER. Yes, sir, by the way that program is to be managed. Do you support this concept or not?

Dr. HAGOOD. In our technical review that we have submitted here with reference to the certificate-of-need programs, the proposed amendment cities come positive elements which could be supported by the Medical Society of Virginia. These include provisions for an annual review of congress made in completing approved certificate-of-need projects, specifying a maximum amount of expenditures and the certificate-of-need approval with adequate justification and documentation supported by recognized professionals in the construction

and health facilities development field and the publication of regulations as to assure conformity to a national certificate-of-need program in accordance with the process described in the review and development of national health priorities.

However, the proposed addition to part "C" of the State health planning and development for an expanded certificate-of-need program would not be supported by the Medical Society of Virginia at this time.

Mr. CARTER. Thank you. Go right ahead.

Dr. HAGOOD. The expansion of certificate-of-need authority to include appropriate, necessary review and recertification is the principal reason for such open significance. While appropriate certificate-of-need review and decertification are not specifically cited in this proposed amendment, the activity of review and discontinuance of health facilities and service decertification are intimately tied to certificate of need action.

For example, section 218 of the proposed health planning amendments of 1978 requires each certificate-of-need design to be consistent with the State health plan. I will skip down to the last paragraph.

The HSA's have not evidenced this technical capacity in their health plans. Hence the expansion of certificate-of-need authority is premature. The HSA's have not documented their ability to consider the impact of their activity on health care quality.

The SHPDA's have not even begun reviewing HSA plans and given the deficiencies and composition of HSA governing bodies would not have adequate representation on the SHCC to review an monitor SHPDA certificate-of-need actions through plan development efforts.

Mr. CARTER. Thank you very kindly.

Mr. ROGERS. Dr. Louis Gibson, State-Wide Health Coordinating Council, we welcome you.

STATEMENT OF LOUIS E. GIBSON, M.D.

Dr. GIBSON. Thank you. I appear here really today in several capacities and would like to talk extemporaneously rather than follow the draft [see p. 741]. I will be happy to answer some of the questions that both Mr. Satterfield and Dr. Carter have addressed to the panel.

I am a private physician in Texas. I have worked in the rural areas of Texas for in an excess of 25 years now. A number of years ago I became concerned about the increasing escalating cost of care and began the development of a private fee for service rural medical care delivery systems encompassing some nine counties in rural Texas.

It has been developed, with a broad base of affiliations between numerous hospital groups and numerous private practice groups, all fee for service, and has resulted in the development of sattelite facilities for the delivery of ambulatory rather than hospital based care.

As early as 1969 we began to document our cost concerns and have as a reference document presented to this committee previously a

thesis entitled "A Rural Medical Care Delivery System," which system described the way we operate.

I also represent the Governor of Texas, Governor Dolph Briscoe. I am authorized to answer any question on health policy in Texas. I represent the Texas area five health system agencies—the Dallas-Fort Worth metropolitan and the 19 county rural area—of which I am president and the State-Wide Health Coordinating Council, referred to under the act as the SHCC of which I serve as chairman.

I also represent the State Health Resource and Development Agency referred to under the act as the SHPDA's which I work very closely with as president of the SHCC.

There are several comments that I would like to make and I would like to break them down into several categories. No. 1, a few comments on the interaction of the various acts that are now being presented to congress and a consideration of how these various acts interact with Pub. L. 93–641.

Although Secretary Califano has assured the congress, and so has Under Secretary Hal Champion, that under Pub. L. 93–641 there is no provisional authority to close any institution, to decrease its service or defer payment to any institution for services delivered under Pub. L. 93–641 is certainly correct, under section 1501 under the guidelines it does say that the health system plan of each health system agency and each State health plan must conform to the guidelines.

These guidelines are those that the act says and which the regulations say, as they appear in the Federal Register, shall be issued as regulations. Our understanding is that guidelines are benchmarks but regulations act as law, as does the act. So health system plans must conform to the guidelines issued as regulations.

A State health plan, a composite of the health system plans in Texas as of 12 individual health system agencies must also conform to these guidelines.

Although Pub. L. 93–641 does not provide for any punitive action, other legislation currently pending in Congress and other legislation potentially pending in Congress mentions the adoption of guidelines. These other acts do have punitive provisions.

It is also possible for the Bureau of Health Insurance and other agencies simply by the promulgating of regulations, to adopt guidelines that have previously been promulgated under this act, Pub. L. 93–641, by the Secretary for Health Planning. It is also possible under rules and regulations of acts already adopted, such as by the Bureau of Health Insurance, to defer payment to an institution for nonconformity to the guidelines they have adopted but which were created under Pub. L. 93–641.

I think this interaction of the various pieces of legislation in Congress when looked at as a whole is a large reason for the concern of both consumers and providers over the Nation and the reaction to the guidelines.

I would hope that each legislative action would be examined to see how Pub. L. 93–641 interrelates to the new acts, and how new acts being considered by Congress would interrelate to Pub. L. 93–641.

Under the guidelines themselves, the guidelines have been modified. I was with Mr. Hurst and Governor Briscoe on December 5th when we met with Under Secretary Hal Champion for something over an hour. I have recorded in my testimony which you have as an attached document, testimony rendered to Secretary Hal Champion.

Secretary Champion did give the assurance that the guidelines would not become enforceable regulations. Now the new guidelines as issued give many means of gaining exceptions to these guidelines.

The problem in Texas is simply this. The exceptions to the guidelines, the 80 percent occupancy, would be more in numerous than the non exceptions, most of the rural areas of Texas. The exceptions to category two, obstetrical care, which defines obstetrical care as any obstetrical care that involves complications of pregnancy—caesarean section—since most institutions do caesarean sections, would be more numerous than non exceptions.

Most category two institutions in Texas at this time do not have 1,500 deliveries a year, most of them do not have 500 deliveries a year.

Pediatrics, category two level, also is quantified as the same category three, providing 15 beds for pediatric units. Most institutions in Texas today delivering category two pediatric services do not have 15 beds.

The point then is that the exceptions to the guidelines, certainly in Texas, are going to be of a far more excessive number than those institutions that do not require exceptions.

Now the new guidelines issued the 20th of January do provide that exceptions may be granted by the health systems agency, documenting the need for these exceptions and including these exceptions in their health systems plan. That health system plan then goes to the State agency, the SHCC and the SHPDA where the exceptions again will be considered and the exceptions then would be documented in the State health plan. That plan then would be considered by the Department of HEW.

I think what I wish to emphasize briefly is this. Even under the new guidelines, health systems agencies, their boards, their committees and their staffs are going to be so involved in the documenting and the defending of the exceptions to the guidelines that they will not be able to devote their time, their budget, their committee structures and their staff to health planning, the development of plans, the implementation of plans and the establishment of their own guidelines which would insure cost effectiveness in their own area.

This then to us in Texas means that this committee should suggest the deletion in section 1501 which says to the maximum extent practice shall be expressin in *quantitative terms* and then let the guidelines which are very fine as benchmarks be used by the individual agencies to develop their own quantative standards for what might be cost effective in their area, but what might be cost escalating in another area.

Regarding board composition, a subject already addressed today, this committee is well aquainted with the law suit previously referred to. In it Texas Acorn under a law suit handled by the Center for Law

and Social Policy, in which Mr. Herb Semmel was plaintiff's attorney, filed suit against Texas area five health systems agency in September and November 1976.

Shortly after the designation in September, the suite was filed, claiming that the term "broadly representative" meant equally proportional representation and that the board was hence out of conformity with the act.

You are also familiar with the fact that this case was heard by the Federal district court in Texas and the Federal district court did indeed rule under summary judgment without hearing, without trial, that Texas area five health systems area board was out of compliance with the act.

That was that its board did not represent categorically proportionately the economic demographic makeup of the area. Sixty percent of the makeup in Texas area five was under 10,000 a year and 80 percent under 15,000 a year.

You are familiar also that this subcommittee then issued some clarification, and that congress issued some clarification of the term "broadly representative." And that the Fifth Circuit Court of Appeals rendered injunctive relief to Texas area five and permitted the continuance of some functions but not the development of health systems plans or review for sometime amounting to about 10 months.

You are also familiar with the fact that in September 1977, the Fifth Circuit Court of Appeals reversed the Fifth Circuit Court and stated simply, and I reference the court of appeals document in the testimony that I have already transmitted to this committee, the Fifth Circuit Court of Appeals said that "broadly representative" does not mean proportional representation.

Congress did not intend under the act to set quotas, that the setting of quotas could be very detrimental to the actual functions of an agency, and that a person of one economic category could actually represent a person of another economic category without being of that particular category.

The court then quoted draft guidelines issued by the Department of HEW in October 1975 as to many of the qualifications that health systems agency board members should have. I would reference you to those guidelines without going into them.

Now this committee then needs, as does congress, to further clarify in the act what "broadly representative" in the eyes of the congress and the court means.

Cost containment, we believe, and cost effectiveness, which is probably a better term, is one of the clear priorities addressed in this act. We believe in Texas that increased accessability to care and cost effective care and identifying and meeting needs are not contradictory but can in effect be done.

We believe that certificate-of-need legislation as it is functioning in Texas is extremely important and should be continued. The State agency in 1977 through December 31, and I believe Dr. Carter, you asked somebody this question on another agency the day before yesterday, had a total of 335 applications. Of these 335 applications 168 were late in the year and are pending.

There have been a total number of applications approved, 144, $69,507,000. There have been a total number of applications denied, 14, a total dollar value of $26,290,000. There has been a total number of applications withdrawn through negotiations or otherwise of nine, with a dollar value of $26,290,000. There has been a total number of applications withdrawn through negotiations or otherwise of nine, with a dollar value of $1,278,000.

That means, then, that either denied or withdrawn there have been $27,568,000 worth of applications involving certificate-of-need.

To answer one specific question now which I heard you ask previously regarding review. In Texas area five health system agency, categorical grant review for the months of November and December, 19 applications were reviewed representing $7,279,000. Most of these were applications that were for continuation grants.

Seventeen were approved. Most of those approved were for continuation grants with a dollar value of $6,711.

Two grants were disapproved because those grants either were inadequately prepared, did not demonstrate significant preparation and organization of the part of the applicant, or evidenced duplicate services that were adequately being provided by other existing agencies. During those 2 months this amounted to $566,000.

I think if there is one thing I can say on cost containment it is this. We need to recognize that there are many elements that are escalating the health care delivery system in this country that can not be addressed by the local health systems agencies. There are some elements that can be addressed. Those elements that can not be addressed are, number one, the way the third party carriers are reimbursed for health care delivery.

The incentive of the patient is to obtain hospitalized care. The incentive for the patient is not to obtain the same care on an ambulatory care basis. We should address third party carriers providing for ambulatory care services.

We need to address reform of cost reimbursement policy. One of the large cost escalating effects on the private health care delivery system in this country is the way the cost reimbursers, the federal payers, so to speak, reimburse the institutions.

They reimburse on their formula less than cost. This reimbursement technique is documented in other documents that I have submitted as part of this testimony. Since they reimburse less than cost and since in many institutions, especially in the rural areas, 60 percent of the cost is reimbursed by cost reimbursers, then the remaining 40 percent in the private sector have to pick up the per day difference.

The cost reimbursers do not reimburse for charity. Private patients have to pick up the indirect cost of bad debts, and the cost of capital accumulation. The net effect is to escalate hospital cost to the private sector.

Sir, I see my time is up. I have two more brief words. Dr. Carter asked somebody, do SHCC's need more money in their budgets? SHCC's do need better funding. They are dependant upon the SHPDA's for their funding. Those funds are transmitted in undesignated budgets. Thank you sir.

[Dr. Gibson's prepared statement follows:]

Texas Statewide Health Coordinating Council

1100 West 49th Street
Austin, Texas 78756
458-7261

Louis E. Gibson, M.D.
Chairman

C. B. Jackson, Jr., M.D.
Vice-Chairman

TESTIMONY TO BE PRESENTED TO:

1. Subcommittee on Health and Environment, House Interstate and Foreign Commerce Committee

2. Senate Subcommittee on Health and Scientific Research, Committee of Human Resources

REPRESENTING

1. The Governor of the State of Texas;
2. The Statewide Health Coordinating Council;
3. Texas Area 5 Health Systems Agency;
4. The Texas Bureau of State Health Planning and Resource Development; and
5. The Texas Medical Association Council on Health Planning.

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ADDRESS SUMMARY

OF

TESTIMONY ON 93-641

I. Consideration of interaction of all health legislation as it affects Public Law 93-641 and 93-641 as it affects other health legislation.

(1) Since local and state health planning agencies are the only agencies authorized by the Act to deal with matters concerning health, it is evident they will be involved in the administration, planning, or implementation of most health legislation.

(2) Although 93-641 provides no authorization for a closure of any institution or decrease in its services or deferment of payment for services by cost reimbursers, for failure to conform to National Guidelines, health systems plans and state plans must conform to these guidelines.

(3) If future legislation such as cost containment, national health insurance, or regulation issued affecting federal cost reimbursers, choose to adopt quantitative guidelines issued by DHEW under 93-641 as their standard, punitive authority not intended under this Act could be invested in other acts.

II. National Guidelines

(1) National Guidelines issued January 18, 1978 are a marked improvement over those previously issued.

(2) These guidelines still require conformity to quantitative standards although methods of exceptions are outlined.

(3) In many areas in Texas the number of exceptions required would be greater than the number of non-exceptions.

(4) State and health planning agency staffs would be required to expend excessive amounts of time documenting and defending exceptions.

(5) It is easy to enforce conformity to guidelines, but far more difficult to insure exceptions.

OBSTETRICAL SERVICES

(1) Most nonurban medium sized communities act as Level II obstetrical units and do not deliver 1,500 birth per year. They maintain a high standard and a cost effective operation. This standard is not acceptable at level II.

NEONATAL SPECIAL CARE UNITS

Most nonurban level II units in Texas do not have 15 beds. They deliver a high standard cost effective service. This standard is not acceptable at level II.

RECOMMENDED AMENDMENT TO SECTION 1501. (b) (2). This section should be amended to read:

> a statement of national health planning goals developed after consideration of the priorities, set forth in Section 1502.

And delete:

> ... which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

The removal of the term quantitative would then allow local and state health planning agencies to develop their own quantitative standards without the necessity of defending exceptions from national standards.

ACCOUNTABILITY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Accountability of DHEW and promulgating rules, and regulations and guidelines could be insured by several modalities.

(1) Ratification of guidelines by the appropriate committees of the House and Senate

(2) Approval of the guidelines by the House and/or Senate.

(3) Ratification of guidelines with the state legislators.

(4) Approval of the guidelines by the governors of the individual state.

III. COMPOSITION OF THE GOVERNING BOARD

(1) Broadly representative. Congress should for once and for all define the term "broadly representative".

(a) This subcommittee has in the past expressed that "broadly representative" does not mean proportional, and that Congress has no intent to set quotas.

(b) The Fifth Circuit Court of Appeals on September 23, 1976 in the suit Texas Acorn versus Texas Area 5 HSA, Joseph Califano, the Secretary of DHEW, Floyd Norman, Regional Health Administrator, made the following specific points:

(1) "broadly representative" does not mean proportional representation.

(2) Congress had no intent to set quotas.

(3) The setting of quotas might hinder the implementation of the Act.

(4) One class may actually represent another class although it is not a member of the class which it represents.

CONGRESS AND HEW, should tract the decision of the Fifth Circuit Court of Appeals.

IV. CAPITAL COST CONTAINMENT

(1) All factors causing the escalating cost of medical care should be considered.

(2) This committee should specifically consider those factors relating to congressional acts and departmental regulation over which the local area has no control.

(3) The method of cost reimbursers, of reimbursing institutions at less than cost, should be addressed.

(4) Methods of encouraging ambulatory fee for service medical care should be addressed.

(a) All third party reimbursers should reimburse for ambulatory care services.

(b) Consideration of issuing tax credits for development of fee for service ambulatory

care facilities should be considered.

(c) Tax incentives for a limited period of time should be looked at as a means of encouraging the development of new medical practices and manpower shortages in rural areas.

V. BIOMEDICAL RESEARCH AND TRAINING

Under no circumstances should medical schools and health science centers have their research and training facilities subject to National Guidelines or to additional local planning agency review, further than that already being performed in specified programs.

Louis E. Gibson

Louis E. Gibson, M.D., F.A.C.S.
Chairman

LEG/bb

Mr. ROGERS. Thank you so much, Dr. Gibson, for your helpful testimony. We do have a call to the floor. Are there any questions at this moment?

Mr. CARTER. I certainly want to thank Dr. Gibson for his fine testimony. As I understand you have a practice there and you have a satellite facility?

Dr. GIBSON. Yes, sir.

Mr. CARTER. I want to commend you on that. You have physicians in those satellite areas?

Dr. GIBSON. We do and they belong to, and participate in the profits of, the main organization, the medical clinic.

Mr. Carter, may I ask you to review the testimony that we have prepared on specific actions that congress might take in the way of legislation to encourage the development of ambulatory care delivery services that will not require infusion of Federal capital but stimulate the infusion of private capital in the hundreds of millions of dollars of infusion capital that is going to be required to develop an ambulatory care system adequate to handle the patient flow if we divert from the hospital base system which we must do.

Mr. ROGERS. Thank you.

Mr. Satterfield?

Mr. SATTERFIELD. Mr. Chairman, I would like to say that I hope that you also will receive the proposed amendments that are going to be sent by HEW. So far as interaction with other legislation is concerned I would like to invite your attention to two of the amendments which I understand will be proposed. They relate to HMO's and the exclusion of HMO's under the cost containment legislation pending before us and what that might mean to the private practice of medicine and to the continuation of private facilities.

Thank you, sir, for being here.

Mr. ROGERS. The committee stands in recess for 10 minutes. When we come back we will hear Mr. Wayne Pressel, an attorney for the Georgia Legal Services, Mr. William Mitchell, a consumer, Atlanta, Ga., Mrs. Mellissa Greene, paralegal, Georgia Legal Services, and Mr. Russ Henderson a consumer.

Thank you for being here. If those witnesses will take their place at the table we will begin as soon as we can return from the vote. The committee is in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. We appreciate the patience of the witnesses bearing with the committee to this late hour. All of your statements will be made a part of the record in full. If you will highlight the points you think necessary for the committee to hear, the committee will appreciate it.

You may proceed.

STATEMENTS OF EVE BISKIND, GEORGIA LEGAL SERVICES PROGRAMS; WILLIE P. MITCHELL, CONSUMER, NEWNAN, GA.; MELISA GREENE, PARALEGAL, GEORGIA LEGAL SERVICES PROGRAMS; RUSSELL HENDERSON, CONSUMER, NEW ORLEANS, LA.; AND WAYNE PRESSEL, GEORGIA LEGAL SERVICES PROGRAMS

Ms. BISKIND. Thank you very much, Mr. Chairman, for your patience at the end of a long day. We are a group from the southeast United States who have come here to say that there are many problems with the act the way it currently is. The HSA system, the way it is currently set up, simply is not working the way Congress intended it to.

Willie Mitchell is a low income consumer from Newnan, Ga., a client of mine. Wayne Pressel is an attorney. Melissa Greene is a paralegal from Savannah, Ga. Russ Henderson is a consumer board member from New Orleans.

I think they will all say things to you today that will show that there are numerous problems with the act and things are not nearly so rosy as perhaps they have been painted by people who have previously testified before this subcommittee.

STATEMENT OF WILLIE MITCHELL

Mr. MITCHELL. Mr. Chairman and members of this committee, my name is Willie P. Mitchell. I am 57 years old. I was born in Coweta County, Ga., and live in a little city called Newnan, Ga., the city of homes.

I hope that what I have to say to you today about health care in my community and surrounding communities in which I have been involved will help you to make your decision on participation of the poor on these HSA boards.

Mr. Chairman, I am a volunteer worker for the Welfare Department which carries medicaid patients from Newnan to Atlanta, to La Grange, to Griffin and the surrounding counties to get a doctor to be admitted to the hospital. We only have about two doctors there which accept medicaid.

Now, we have a clinic there with all the best doctors, which is called Pap Clinic, but Pap Clinic does not accept medicaid. Medicaid is for people with incomes of about $141 a month for a family of four.

I came here to ask for your support for these low-income people. I might say poor people. Sometimes when you say poor people, people kind of get angry with you. I cannot help saying that because I am poor myself.

Mr. Chairman, what we need is some concrete steps taken in our North-Central Georgia HSA to insure public participation, to insure that poor people represent themselves.

Mr. Chairman, I have seen firsthand people who were poor that could not pay a doctor and were turned away from a doctor's office. I have seen this.

I have also seen people go into the emergency room of the hospital and call for a doctor. In one case this doctor told a young lady—I have her affidavit—"If you have $30 I will come to the hospital to see you." I had to bring her back home without seeing a doctor. This young girl is pregnant. She is about 7 months, something like that, and she does not have a doctor.

Then I went back to the welfare office to try to see what I could do for this young lady. They could not give her anything to pay the doctor. So, we have what we call in Coweta County a health office, a clinic. They have been doing some improving but it is not up to date. But they saw her there.

So I would like to tell you about what HSA has done. We have two hospitals there, Mr. Chairman. One is Coweta General which serves the total community. The other one is Newnan Hospital, which serves only white people.

Newnan Hospital put in a request for renovation funds, about $2,000,000. Coweta General, which serves the total community, put in for renovation for about $900,000. HSA voted and approved both of these requests, although the Newnan Hospital does not serve the total community, does not serve black people. The Newnan Hospital also used Coweta General medical equipment, such as nuclear medicine, that I do not think they have at Newnan Hospital.

If I and many more poor people in that community had been on that board, we would have disapproved Newnan Hospital. We would not have voted for it. We would have disapproved it because I, and I am speaking for a lot of people like me, want to see all people get the best of medicine.

We would like for this committee to tell Congress to give the poor people a chance and let us show what we can do. We have some good minds in our poor community. We know what it is all about. We know, we live there. I am in contact with it every day of my life. We want a chance to serve on these HSA boards and be a part of this program and make it a great program.

Mr. ROGERS. Thank you very much, Mr. Mitchell, for a very helpful statement.

STATEMENT OF MELISSA GREENE

Ms. GREENE. Thank you for your time this afternoon. I am Melissa Green. I have been a paralegal with Georgia Legal Services in Savannah for the last 2½ years. In the last year I have been working with a grass roots organization called Coastal Health Action Group. I want to respond to some of the testimony that was given to the committee on Monday by the Southeastern Association of HSA Executives.

Their publication, "Progress through Participation," gives the impression that in the southeast consumers and providers are working

together to change the share of the health care system, to reduce costs, and to provide for greater access.

My experience has been in the southeast Georgia HSA, one of the seven in Georgia. I must say for our area that the impression that this book gives is a false one. I live and work in downtown Savannah, which has the greatest concentration of poor and black and elderly and disabled people in the whole region.

From my observation the access problems have not changed at all in the few years HSA has been there. The people are not included in the planning process.

Like Mr. Mitchell, I have seen examples of people denied health care. There are hospitals in our region that will not treat people until they have money up front, which means if you go to the emergency room and you do not have the money they will turn you away. We have talked to young girls and that would mean giving birth to babies in shacks, for example. We have affidavits on that.

The description in this publication is sheer fantasy. In our area most of the consumers are still outsiders to the health planning process. A few consumers have been able to storm the fortress of the health planning and have gotten elected to the board of the HSA. But even those consumers feel confused and uneducated and intimidated by the providers on the board. Meanwhile the providers in our area seem to be engaged in wars of expansion. There is not much cooperation happening.

I want to give one example of an issue in our area that came before the HSA board last year. It was an opportunity for the HSA board to approve a facility for downtown Savannah that would immediately benefit the needs of the high health-risk population groups in downtown Savannah. But the board refused to act on it.

In the fall of 1976 a public health clinic was proposed by the United Way people in Savannah to serve the downtown population. All the HSA was asked to do in this case was to request designation by HEW of the downtown Savannah area as medically underserved.

I should briefly describe the population of downtown Savannah. It has a population of about 55,000; nearly half the people are poor, nearly 13 percent are elderly. In the whole downtown area there are only five doctors that are accepting new medicaid patients.

There is a downtown hospital, but it is planning to move in the near future, which will leave downtown without patient facilities or an emergency room or inpatient facility. That hospital relocation will take doctors and services with it out of the area.

There is a county indigent care clinic, but it takes an hour to reach by bus. Downtown Savannah meets the criteria for medically underserved.

A few months after this issue was raised in the HSA, the Federal Register listed downtown Savannah as one of the areas in the country meeting that designation of medically underserved.

The HSA board refused to approve this designation. Starting from October 1976 until April 1977 they repeatedly tabled the motion. There were medical society members on the board of the HSA. Some of them were doctors with private practices or large medicaid practices in downtown Savannah. They were influential with the board and kept killing the proposal every time it came up.

At one of the meetings I went with some of the people from the legal services staff and we took affidavits we had obtained from people who lived downtown, pleading with the board to consider this clinic proposal. In response to that, the board appointed a task force committee to look into the proposal. They appointed as chairman of that committee one of the private doctors with a practice in downtown Savannah.

So we were not optimistic about the findings of that task force. Finally, in April of 1977 the board met to consider rejecting the proposal altogether. But then the group I mentioned, the Coastal Health Action Group, had organized and mobilized 60 people who went down to the executive board meeting in a demonstration of their support for the clinic.

The group's attorney made a presentation to the board, for the first time explaining what the criteria for medically underserved were and the fact that downtown appeared to meet them. At that meeting the consumer board members understood what was happening, and the vote changed.

During all that time no outside opinion had been solicited. The people in downtown Savannah had not been asked to give their opinion on the clinic. It was obviously in response to our presence there and to the public attention we brought to focus on that issue that we got any action at all.

I tell this story to demonstrate that consumers and especially poor people are aware of the Planning Act and also are aware that their involvement in it is critical, that it can be the difference between getting services and not getting services. I believe that the consumer decisions will tend to be cost containing and will address the need of the underserved community but that the groups that have traditionally been in control of the planning process are reluctant to give up that authority.

So I am urging the Congress to try to strengthen the legislation, to strengthen the support that consumers are given, both to get into the planning process and to help protect the input once they are within the system.

Mr. Rogers. Thank you very much, Ms. Greene.

STATEMENT OF RUSSELL HENDERSON

Mr. Henderson. I am Russ Henderson. I am a consumer member of the New Orleans Bayou Area Health Systems Agency which is a self-selecting, self-perpetuating board.

My major concerns are cost containment and equal access to health care. My HSA comprises 11 parishes, or counties, of the greater New Orleans area. It has a 5.7 per thousand bed population. Today consumers and the Federal Government are expending approximately $135 million for 2,200 unused beds, and that is a conservative estimate. This figure will continue to grow as long as my HSA continues to approve these hospital beds.

As I have said, I am also interested in access. I would like to address my remarks to that. To exemplify our inability to achieve the goals of access in our HSA, I would like to point out that the Office of Civil Rights under title VI of the 1964 Civil Rights Act has issued letters of findings to four hospitals in our HSA saying that they are charging them with racial discrimination.

I will not go into all the particular figures, but the aggregate figure for those four hospitals is 53,191 patients in all four of those hospitals. Out of that total, 2,822 are black. Two of those hospitals are located in predominately black neighborhoods in the city of New Orleans. That is about 5.5 percent of their total population. The city population is around 50–50, black and white.

Since Dr. Carter mentioned Oschner yesterday as an example of a hospital providing quality care, I would like to point out that of the 14,134 admissions to Oschner, according to the Office of Civil Rights report, only 899 of those were black.

Within a 5-mile radius of the hospital there are 14,000 blacks. Only 1.7 percent of those 14,000 who received hospital care went to Oschner. To quote the findings of the OCR report, the facts indicate that harm was suffered by the blacks because of the underutilization by blacks of the Oschner Foundation Hospital.

There are no black interns or residents, no blacks on the board of trustees. No attempt was made to inform medicaid patients of potential access to Oschner Foundation Hospital, so only 53 of that 14,000 admission figure were medicaid. There are approximately 85,000 people in the area who are participating in medicaid.

In a few days our board will be considering an application from West Jefferson Hospital for a $35 million expansion and renovation. West Jefferson is under investigation for Civil Rights violations. I am not going to go through the specific figures again but they are startling, also.

None of the staff review or the committee meetings of the HSA have brought up this investigation of racial and economic discrimination. It is absurd that a HSA can make a final decision on any hospital application when there is a pending title VI investigation or when a title VI report has been made stating that the hospital commits racial and economic discrimination.

Our agency does not collect adequate racial data for the hospitals in our area. More importantly, there is a lack of clarity in our agency, and I think with most of the other agencies, on exactly what the role of the HSA is in light of title VI of the Civil Rights Act.

HEW has not addressed this, and clarification from the Congress in this area would be of particular importance.

I have consistently referred to medicaid statistics. They have great relevance since in Louisiana approximately 80 percent of all persons participating in the medicaid program are black. Thus, denying access by medicaid patients constitutes denial based on race and economic status which is contrary to the Planning Act and title VI.

I am encouraged by the proposed amendment to section 1534(c)(2) that mandates backup centers for HSA's. I think it is particularly important that consumer-oriented board members, low-income consumers and their representatives, have the technical skills necessary to tackle the problems of access to health care.

Our testimony lists on pages 12, 14, and 22 specific recommendations concerning access to medical care. I would hope that you would look at these recommendations and give the HSA's the guidance that they need to be able to deal specifically with the problem of access to health care.

Thank you very much.

Mr. Rogers. Thank you very much, Mr. Henderson, for your statement.

STATEMENT OF WAYNE PRESSEL

Mr. PRESSEL. Mr. Chairman and Dr. Carter, I will make my remarks brief and to the point. My name is Wayne Pressel. I am a lawyer in Atlanta, Ga. For 6 years I practiced with Georgia Legal Services and devoted a great deal of that time to health law issues.

During the past year I have also been lead counsel in the case of *Rakestraw* v. *Califano*, a law suit in Federal court in Georgia challenging both the selection processes and the board composition of each HSA in the State.

Mr. Mitchell is one of the named plaintiffs and my client in that case. You have heard testimony from Mr. Mitchell as to the situation in health care in Coweta County and the surrounding area and the failure and refusal of the HSA to deal with it.

You have heard from Melissa Greene about her experience in Savannah with provider domination of the HSA there and the difficulties of consumers in having access to any policymaking surrounding the Public Health Service Clinic there.

You have heard from Russ Henderson concerning the access problems and racial discrimination that run rampant in New Orleans.

In all three of these situations we seem to find two common problems. These are problems which, I believe, this subcommittee and Congress need to address.

The first problem is that of provider domination. It is a natural situation of health care in this country that consumers simply, by the way things are operated, do not have the ability to have full, equal, and meaningful participation in health care planning.

The second problem which I think this committee needs to face is the repeated failure and refusal of HEW to address the problems that it faces. That HEW has not issued any regulations dealing with board composition or the selection process beyond simply parroting the statute, is unforgiveable.

That as far as HEW has gone was to—I think it was in October 1976—put out some draft guidelines that were never implemented is something that this committee can not overlook. The fact that HEW has not to this day, although it has long promised to do so, issued any regulations to clarify or to make more concrete the rights and powers of consumers is something that this committee needs to address.

For example, I think it fits very well with Mr. Mitchell's testimony that I submitted to HEW on the reapplication for conditional designation by the North Central Georgia HSA, documents and proof that many indirect providers were sitting on the board of the HSA as consumers and with undoubted proof of the illegal composition of the board under anyone's configuration of law.

HEW chose to do nothing, chose not to investigate. They did not even contact any of the people making the allegations but simply went ahead and approved for further conditional designation the grant of the North Central Georgia HSA.

Simply put, I think the situation is that this committee and this Congress cannot rely on the natural situation between providers and

consumers to work in an effective and meaningful way to increase quality of health care and bring about all cost containment that is reasonable.

I think it is equally clear that this committee cannot rely on the Department of Health, Education and Welfare to implement the designs and purposes of the Act. It is clear to me that the leadership and the responsibility for the altering of the health care system in this country is squarely before this committee and squarely before the Congress.

If this committee and this Congress does not take the leadership, if it does not clarify the situation, if it does not give consumers the rights and powers and mechanisms to seek those rights and powers, then the Act is going to remain as meaningless and unfulfilled as it is today.

And 1 year, 2 years or 10 years from now you will hear of the same tragedies from the South and from virtually every State in this country.

I appreciate your attention.

[Testimony resumes on p. 875.]

[The prepared statement of the Legal Services Clients is as follows:]

TESTIMONY ON BEHALF OF

LEGAL SERVICES CLIENTS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

FEBRUARY 1, 1978

REGARDING

THE HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

(H.R. 10460)

AND

TITLE III OF THE HOSPITAL COST CONTAINMENT ACT OF 1977

(H.R. 9717)

Presented by:

Georgia Legal Services

Atlanta Legal Aid Society

New Orleans Legal Assistance Corporation

National Health Law Program

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SUMMARY OF TESTIMONY BY THE GEORGIA LEGAL SERVICES PROGRAM, ATLANTA LEGAL AID SOCIETY, NEW ORLEANS LEGAL ASSISTANCE CORPORATION, AND NATIONAL HEALTH LAW PROGRAM

The poor have traditionally been excluded from the health planning process. Although low-income people have a vital interest in securing accessible quality health care at a reasonable cost, they have once again been denied the opportunity to participate in decision-making. Congress sought to establish in the National Health Planning and Resources Development Act a consumer-oriented planning process with the benefit of input from the poor. To date, this goal has not been achieved.

This testimony is presented on behalf of low-income clients represented by legal services attorneys across the country pursuant to 45 C.F.R. §1612.4. It was prepared on the basis of consultations with legal services clients, paralegals, attorneys, and health planners in 40 states. The testimony demonstrates how participation by low-income consumers has been frustrated and suggests proposals to enable the legislation to achieve "equal access to quality health care at a reasonable cost."

Willie Mitchell is a low-income disabled black man who lives in rural Georgia. He is an advocate for the poor in his community. He has seen the consequences of decisions made by improperly constituted HSA boards on the poor. In Mr. Mitchell's hometown, as in many other area of the country, unrepresentative boards have approved expansion of private institutions which offer little or no service to the surrounding poor and minority communities. These consequences could be avoided by reconstituting HSA boards in a truly representative manner.

Russell Henderson is a consumer board member of the HSA in Southeastern Louisiana. The median family income in the health service area is under $15,000. To comply with the "broadly representative" requirement of the Act, 7 of the consumer members on the Executive Committee should have incomes below $15,000. Only 1 does, however.

The eleven parishes in the Southeastern Louisiana health service area contain far too many hospital beds, but also far too few hospitals accessible to the poor and the black. A hospital in the health service area recently applied for approval of a $35 million expansion. This hospital is presently under investigation by HEW's Office of Civil Rights for racial discrimination. Despite the pendency of this investigation, the health systems agency has failed to consider the discriminatory practices of the hospital. Moreover, the agency has indicated its tentative approval for the expansion despite the significant overbedding in the community. These types of decisions could be avoided if low-income persons had meaningful representation on boards.

Marty Ellin is an attorney with the Atlanta Legal Aid Society who has documented the inaccessibility of current health care institutions and practitioners to low-income consumers throughout rural Georgia. This inaccessibility results from four main causes. First, geographic barriers such as transportation prevent access to health services. Second, few providers accept Medicaid; many charge prohibitive fees in advance for their services. Third, poverty often prevents patients from following treatment plans that include such recommendations as prescription drugs. Fourth, few providers

are willing to locate in rural areas. Although HSAs are required to address these problems, most have failed to fulfill this statutory obligation.

Wayne Pressel is a former Georgia Legal Services attorney who was actively involved in the fight to increase consumer representation on HSA boards. In most of the HSAs he investigated, providers were responsible for the creation and perpetuation of self-selecting and unaccountable governing bodies. As a consequence, the disenfranchised poor have been unable to gain access to the health planning process.

Anne A. Smart is a welfare and Medicaid recipient from Louisiana. The HSA in her service area has drafted a health systems plan that does not even recognize the existence of over 100,000 black sugar cane workers who live in the area. The plan also does not address the significant health problems of this visible medically underserved population. Such defects result directly from the lack of significant low-income membership on the HSA governing body.

These experiences and the other testimony demonstrate that the prohibition on self-selecting boards is an important starting point. It is not sufficient in itself, however, to realize the goal of truly representative HSAs. Nominating committees may still limit the representation of the poor and medically underserved. Selection of members by elected officials without reference to the representativeness requirement may still thwart consumer involvement.

Melissa Greene is a paralegal with Georgia Legal Services

in Savannah. Her work with a grass roots organization demonstrates the possibilities for consumer participation. Consumer involvement has been translated into progressive decisions. Representatives of underserved populations have even been elected on the HSA when an open selection process has prevailed. As indicated in the testimony, this experience is not an isolated one.

The need to assure meaningful consumer participation must be addressed when Congress considers amendments to the National Health Planning and Resources Development Act. Meaningful participation, however, requires more than mere representation. It requires education and technical support. It requires sensible scheduling of meetings and financial support to defray expenses. The effort necessary, however, is more than justified by the quality of the result.

The need to make health systems agencies accountable to the community has led to substantial litigation. Litigation has proven to be an inadeqaute tool to achieve this goal, however. HEW has been unwilling to fill this void by taking steps to approve only those HSAs which are truly representative of the population of the health service areas. The burden is now on Congress to act. What is at stake? The promise of "equal access to quality health care at a reasonable cost."

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Georgia Legal Services Program

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Andy Schneider
National Health Law Program

Jack Mark Stolier
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ISSUE:

Representativeness of the governing body

PROBLEM:

Section 210 is not adequate to insure that the Governing Body and Executive Committee are truly representative of the population in the health service area.

RECOMMENDATION:

Amend section 1512(b)(3)(C)(i) to read as follows: "A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care. The composition of such consumer membership shall roughly approximate the demographic characteristics of the health service area with regard to race, sex, income, age, and language, geographic areas, and shall include major purchasers of health care and at least one representative of the handicapped. An individual selected to represent a particular group need not be a member of that group only if the Secretary finds that such individual was selected by an organization composed primarily of members of that group to represent its interests."

DISCUSSION:

The prohibition on self-perpetuating governing bodies is an important step in the direction of insuring consumer majorities that are broadly representative of the consumer interests in the health service area. This prohibition, however, will not insure that the consumer membership is truly representative. The survey data includes a sample of health systems agencies with governing

bodies that are neither self-perpetuating nor representative.

The language "roughly approximate" will insure representativeness but will also allow limited variations. This will allow health systems agencies to include, for example, representatives of substantial racial populations that are not sufficiently numerous to allow representation under a precise proportional standard.

The importance of insuring broad consumer representation has been long acknowledged by Congress (see, for example, Senate Report, No. 93-1285, 1974 U.S. Code Cong. & Admin. News, 7842, 7885; Congressional Record, House, December 20, 1974, p. 41854.) While the importance of consumer representation is accepted, the role that it plays is often forgotten.

The presence of consumer representatives can insure that consumer interests are meaningfully addressed in such important functions as certificate of need review. The testimony sets forth some examples of the impact that consumer representation can have in insuring that such important issues as access for low-income consumers are considered. Unfortunately, the testimony also points up the effect that the absence of consumer representation can have in formulating a health systems plan that fails to consider such important consumer concerns as access and cost containment.

ISSUE:

Representativeness of health systems agency committees

PROBLEM:

Committees are often appointed by the governing body which are not representative of the health service area population.

RECOMMENDATION:

Amend section 1512(b)(3)(C)(iv) to delete the phrase "of its members" in addition to the phrase "to the extent practicable" which section 115 would delete.

DISCUSSION:

Many health systems agencies utilize committees to perform such important functions as certificate of need review. Often these committees include individuals who are not members of the governing body or executive committee.

As currently provided, section 1512(b)(3)(C)(iv) would not require broad representation on such a committee since it is neither a subcommittee of the members of the governing body or executive committee nor is it an advisory group. For the same reasons that section 1512(b)(3)(C)(iv) now requires representativeness, the requirement should be extended to all committees of the health systems agency.

ISSUE:

Selection of governing body and executive committee

PROBLEM:

Section 210 does not prohibit the governing body or executive committee from selecting nominee slates. Section 106 implies that members must be appointed and not elected.

RECOMMENDATION:

Amend section 1512(b)(3)(D) (added by section 106) by striking the word "appointed" in clause (D)(i) and inserting in lieu thereof "selected", and adding after "body, committee, or entity," the words "and shall prohibit the selection of nominee slates by members of such body, committee, or entity."

DISCUSSION:

The mere prohibition on self-perpetuating boards does not insure that the selection process will truly be open. Many Health Systems Agencies utilize a single slate of nominees, selected by a committee of the governing body, which may then be presented to elected officials for selection. In this way, the governing body maintains control over the selection process.

By prohibiting single slates of nominees consumers can gain access to the selection process in order to insure that members satisfy the requirements of section 1512(b)(3)(C).

Finally, the use of the word "appointed" in section 1512 (b)(3)(D)(i) seems to imply that HSAs are prohibited from electing members. Since this was not the intent of Congress, this language should be modified.

ISSUE:

Reimbursement for consumer representatives

PROBLEM:

Meaningful consumer participation is often frustrated by the need to front expenses attributable to HSA activities.

RECOMMENDATION:

Amend section 1512(b)(3)(B)(vi) by striking out "reimburse" and by inserting in lieu thereof "reimburse (or when appropriate make advances to)" and by striking out "incurred in attending meetings of the governing body" and by inserting in lieu thereof ", including travel, meals, and child care, incurred in attending meetings of the governing body and in performing other agency functions."

DISCUSSION:

Many low-income consumers are unable to pay for the costs of participation in HSA activities despite the promise of ultimate reimbursement by the HSA. Moreover, many of the important functions of the HSA are performed not by the governing body, but by committees performing such functions as certificate of need review. Limitation of reimbursement to governing body meetings would therefore reduce consumer particpation in important activities of the HSA.

Section 213 therefore represents a step in the right direction in attempting to insure consumer involvement. It is, however, too limited in its scope.

ISSUE:

Consumer resource staff

PROBLEM:

Consumers often come to the HSA without sufficient technical expertise or familiarity with medical jargon to allow meaningful participation in HSA functions.

RECOMMENDATIONS:

Amend section 1512(b)(3) by adding after subparagraph (E) (added by section 213(a)) the following new subparagraph:

"(F) Each health systems agency shall have a consumer resource staff which is selected by and accountable to consumer members of the health systems agency. The consumer resource staff shall be sufficient, in accordance with standards established by the Secretary, to perform the following functions: (1) education of consumer members with regard to health care and health planning; (2) encouragement and facilitation of involvement of consumers in HSA functions; (3) provision of technical assistance to consumer members; (4) attendance at and monitoring of board, subcommittee and advisory group meetings; (5) review of proposed health systems plans, annual implementation plans, grants, contracts, project reviews, and certificate of need applications; (6) facilitation and review of solicitation, slotting and election of board members; and (7) evaluation of the effectiveness of the health systems agency in achieving its stated goals. In order to carry out these functions, each health systems agency shall devote not less than 5 percent of its budget for an identifiable program of public education and participation.

DISCUSSION:

While consumers can make valuable contributions to plan functions because of their awareness of community needs and community interests, their meaningful participation may be hampered by their unfamiliarity with technical jargon or their inability to synthesize financial data. This exacerbates provider domination in such important functions as certificate of need review. This problem is described in the testimony.

In addition, many HSAs have been seriously deficient in attempts to encourage consumer involvement. By insuring that every HSA will have at least one staff person with these goals as his/her sole concern, meaningful consumer participation can be insured in all plan functions.

Section 213(a) represents a step in the right direction by attempting to insure adequate staff support to carry out HSA functions. Section 213(a) does not recognize, however, the superior position that providers have with regard to access to technical expertise and facility with medical terminology and financial data.

ISSUE:

Appropriateness review - standards

PROBLEM:

Existing law does not explicitly provide the standards that should be applied in conducting appropriateness review.

RECOMMENDATION:

Amend section 1513(g) by adding at the end thereof the following new subparagraph:

"(3) In making the appropriateness review required by paragraph (1), each health systems agency shall address at a minimum issues of need, geographic accessibility, economic accessibility, physical accessibility, financial viability, costs and charges to the public, quality of service provided, and compliance with applicable requirements of federal law prohibiting discrimination on the basis of race, color, national origin, sex, age, indigency, source of payment, or disability."

DISCUSSION:

There is a need to establish criteria to guide health systems agencies in conducting appropriateness review. The appropriateness of a health service should be considered in light of such factors as the accessibility of the health services to low-income consumers. This in turn should include such criteria as the geographic accessibility (in light of the availability of public transportation), economic accessibility (whether or not the facility accepts Medicaid or Medicare or provides charity care), and physical accessibility (whether an existing facility has been modified to permit access for the handicapped).

ISSUE:

Criteria for review - quality of care

PROBLEM:

Present criteria do not allow the health systems agency and State agency to consider the record of the applicant in providing quality of care.

RECOMMENDATION:

Amend section 1532(c) by adding subparagraph (12) to read as follows:

"(12) In the case of existing facilities or services, the quality of care provided by the facility or service in the past."

DISCUSSION:

Section 1502(6) establishes as a national health priority to achieve needed improvements in the quality of health services. Section 1513(a)(2) similarly establishes as a function of the health systems agency to increase the quality of health services.

In light of these stated goals, it would be incongruous to award a certificate of need to a facility that has been providing substandard care in the past so that it can provide expanded substandard care in the future. Section 123 includes quality of care as a criterion of appropriateness review for this reason. Health systems agencies that have attempted to include quality of care as a criterion in certificate of need review, however, have been largely unsuccessful. (See testimony of Catherine McBride.)

Health systems agencies are required by section 1513(d) to coordinate their activities with professional standards review organizations in the health service area. This will insure that there is not duplication of efforts and that the findings of the PSRO and other evidence will be utilized in the health planning process.

ISSUE:

Criteria for review - accessibility

PROBLEM:

Certificate of need criteria do not adequately address the geographic, physical, and economic accessibility of the proposed health service, institution, or facility.

RECOMMENDATION:

Amend section 1532(c) by adding subparagraph (10) to read as follows:

"(10) The geographic, physical, and economic accessibility of the health services proposed to be provided to low-income and minority persons and women."

DISCUSSION:

The denial of access to low-income and minority persons has been a focus of increasing concern recently. (This problem and and report of the Congressional Budget Office documenting its extent are discussed in the testimony.) While health care costs have continued to rise at an alarming rate, this has been accompanied by an increasing recognition that many individuals do not have access to basic health care. In many communities, women are subject to such restrictions as sterilization requirements before providers are willing to provide treatment. In many other communities, such basic services as obstetric and gynocological services are simply unavailable under any circumstances.

Congress established as one of the functions of the health systems agency to increase the accessibility of health services in section 1513(2). Certificate of need and section 1122 review

are therefore conducted based on the general need in the community for the health service proposed to be provided. The person proposing to provide this service, however, may by policy or practice exclude significant portions of the consumer community from access to the facility. The need for the health services should therefore only be considered in light of the population which may be ultimately served by the facility.

While the Hill-Burton assurances and the guarantees of Title VI of the Civil Rights Act and section 504 of the Vocational Rehabilitation Act are important in this regard, they are not adequate to insure access in many health services. While health systems agencies do not presently have the power to insure compliance by all health service providers with these safeguards, inclusion of this criterion would insure that a certificate of need would not be granted on the basis of an unmet need in a population which the health service provider will not serve.

ISSUE:

Review procedures

PROBLEM:

Many health systems agencies have not established adequate safeguards to insure the integrity of the review process.

RECOMMENDATION:

Amend section 1532(b) by adding the following paragraph at the end thereof:

"(12) In the case of reviews pursuant to subsections (f) and (g) of section 1513 and subsections (4), (5), and (6) of section 1523, and where appropriate for other reviews-

"(A) presentation by each participant, if requested by such participant, of evidence and arguments orally and/or by written submission,

"(B) maintenance of a record of the hearing,

"(C) provision that the decision of the agency and Agency be based solely on the record of the hearing, and

"(D) prohibition on ex parte contacts with individuals voting on the review process."

DISCUSSION:

The review process required by section 1532 fulfills the requirements of a quasi-judicial proceeding. A hearing is required to be held; evidence is required to be taken; findings are required to be made. Despite this fact, review hearings are often run with excessive informality at the expense of impartiality. This has been the focus of many complaints regarding the integrity of the review process. (Some examples of these complaints are contained in the testimony.)

The proposed changes would not overly restrict access by

reviewers to necessary information. These safeguards would insure, however, that such information would be a part of the hearing record, that decisions will be made solely on that record, and that the impartiality of the review process will not be compromised.

ISSUE:

Conflict of interest on the SHCC

PROBLEM:

The present law does not prohibit persons on the SHCC from participating in matters before the SHCC in which they may have a conflict of interest.

RECOMMENDATION:

Amend section 1524(b) by adding at the end thereof the following new paragraph:

"(4) A SHCC shall adopt procedures in accordance with regulations promulgated by the Secretary to insure that no member, employee, consultant or agent participates in any matter regarding any person, institution, organization or other entity with which he or she has or has had within the past three years any substantial direct or indirect employment, fiduciary, competitive, or ownership or other financial interest."

DISCUSSION:

Section 214 adds a provision prohibiting conflicts of interest on the governing bodies of HSAs. The equally pervasive problem of conflicts of interest among members of SHCCs, however, are not addressed. The proposed change would remedy this problem.

ISSUE:

Discontinuation, reduction, conversion, or relocation of health services

PROBLEM:

The State certificate of need and the federal section 1122 review processes are not currently applicable to the discontinuation, reduction, conversion, or relocation of health services in low-income or rural communities.

RECOMMENDATION:

Add section 1527(a) to read as follows:

"The certificate of need program required by section 1523(a)(4)(B) shall provide for the following:

(1) Review and determination of need under such program of--

(A) major medical equipment, health care facilities, institutional health services, and home health services, and

(B) capital expenditures,

shall be made before the time such equipment or facilities are acquired, such services or facilities are offered or developed, substantial expenditures are undertaken in preparation for such offering or development, capital expenditures are obligated, or before such services or facilities are discontinued, reduced, converted, or relocated, in whole or in part, or before such equipment is sold or transferred.

(2) The acquisition, offering, and development of only such equipment, facilities, and services as may be found by the State Agency to be needed; and the obligation of only those capital expenditures found to be needed by the State agency;

(3) The discontinuation, reduction, conversion, or relocation, in whole or in part, of only such facilities or services as may be found by the State Agency to be unneeded (with special consideration for the needs of medically underserved populations), and the sale or transfer of only such major medical equipment as may be found by the State Agency to be unneeded, provided that an application under this subsection shall not be denied if the applicant demonstrates that such denial would result in the loss of financial solvency and that no less drastic alternative is available."

Add section 1527(c) to read as follows:

"In performing reviews as the designated planning agency under secion 1122 of the Social Security Act pursuant to section 1523(a)(4)(A), the State Agency shall take into account the same recommendations, as with respect to criteria set forth in subsection (a)."

DISCUSSION:

It is not uncommon for hospitals to close departments or phase out services which are in and of themselves unprofitable, even though the facility's overall financial health may be sound. These closures or phase outs can be particularly devastating for the poor if, as is often the case, the clinics or departments involved are the source of scarce emergency room or outpatient services.

Similarly, over the past several years a pattern has emerged whereby private hospitals located in low-income inner city neighborhoods either transfer their facilities to outlying suburban areas, or establish satellite facilities in suburban

areas which then drain needed resources away from inner city communities. The result is a denial of access to needed services by the poor and minorities.

Few if any state certificate of need laws now apply to such decisions, and the issue as to whether section 1122 review would apply is now in litigation. This language would mandate state-administered regulatory controls to prevent such discriminatory capital expenditure decisions while taking into account the need to assure the financial viability of the facilities.

ISSUE:

Criteria for review -- existing federal obligations to serve the community

PROBLEM:

Current State certificate of need and federal section 1122 review requirements do not assure that applicants have fully complied with their existing obligations under federal law to serve the community without discrimination on the basis of race, ethnicity, source of payment, and in some cases ability to pay.

RECOMMENDATION:

Add section 1527(d) to read as follows:

"In performing reviews under subsections 1523(a)(4)(A) and 1523(a)(4)(B), a State Agency shall not grant section 1122 approval or issue a certificate of need to any applicant unless such applicant demonstrates that it has in the past fully complied, and that it will in the future fully comply with:

(1) the community service and uncompensated services assurances given by such applicant in connection with the receipt of assistance under Titles VI or XVI of this Act, if any;

(2) the requirements of Title VI of the Civil Rights Act of 1964, if applicable; and

(3) the requirements of section 504 of the Rehabilitation Act of 1973."

DISCUSSION:

In authorizing the distribution of federal funds to health care providers, Congress has long insisted that facilities and

practitioners receiving such assistance make their services available to the entire community, without discrimination on the basis of race, handicap, source of payment, etc. This federal assistance comes in many forms, including Medicare and Medicaid reimbursement, Hill-Burton construction and modernization subsidies, etc.

Unfortunately, many facilities that have received federal funds do not comply with these federal obligations. Some examples of discrimination on the basis of race and denial of service to poor people are discussed in the testimony.

Although mechanisms now exist for the enforcement of these statutory obligations, they are not sufficient. For example, DHEW, which is charged with enforcing Title VI nondiscrimination assurances, has not taken effective action in the face of widespread noncompliance. Additional enforcement mechanisms are required. The health planning process generally, and the capital expenditures review processes in particular, represent an appropriate forum for an assessment of compliance with outstanding federal obligations that are designed to assure access by the entire community to care.

ISSUE:

"Voluntary" discontinuance of needed hospital services

PROBLEM:

Title III of H.R. 9717, which would establish a program to encourage the discontinuance of unneeded hospital services, does not contain adequate safeguards to prevent the closure of public general hospitals serving urban poverty populations.

RECOMMENDATION:

Add to section 305 a subsection (d) to read as follows:

"(d) The provisions of this subsection shall not apply to any urban public general hospital, whether operated or owned by a State, city, town, county, borough, hospital district authority, or public or quasi-public corporation."

DISCUSSION:

In many overbedded urban areas, the public general hospitals play a critical role as the institution of last resort for the poor and for minorities. For low-income persons who are denied needed services by the private voluntary institutions, the public hospitals provide essential outpatient and inpatient services.

While the goal of reducing excess bed capacity is an appropriate one, the danger in Title III is that, in targeting hospitals to discontinue services to bring their areas into compliance with the national guidelines, HSAs will pick on the facilities that are most vulnerable politically, without regard to the implications for access by low-income persons - i.e., the public hospitals. The only effective way to prevent this disastrous result is to recognize the pivotal role these facilities play in delivering care in urban underserved by exempting them altogether from the penalty provisions.

TESTIMONY BY RUSSELL HENDERSON

I am Russ Henderson. I am a life-long resident of Louisiana and currently reside in New Orleans. For the past 2 years I have served as an Executive Committee member on the Board of Directors of the New Orleans Area/Bayou Rivers Health Systems Agency serving Southeastern Louisiana. I am a consumer board member and have great concern that the goals of equal access and cost containment set forth in the National Health Planning and Resource Development Act cannot be obtained unless this Congress addresses the difficult questions concerning the selection and makeup of the governing bodies of HSAs.

Health Service Area I (HSA I) is composed of eleven parishes (counties) surrounding and including the greater metropolitan area of New Orleans. HSA I contains 5.7 beds per thousand patients. Greater New Orleans contains 6.6 beds per thousand patients while New Orleans itself contains 8.8 beds per thousand patients.[1] These numbers far exceed the HEW guidelines of 4 beds per thousand.[2] Today consumers and the federal government pay $138,700,000 for the 2235 unused beds in HSA I and if my HSA continues to approve additional unneeded beds, this figure will far exceed that present amount.[3]

1/ Draft HSP, New Orleans Area/Bayou Rivers Health Systems Agency, 1978.

2/ National Guidelines for Health Planning, 42 C.F.R. §122.1, 43 Fed. Reg. No. 14, pp. 3063 et seq., Jan. 18, 1978.

3/ These figures are computed from the 8130 non-federal plus 1183 federal short term general hospital beds (NOA/BR draft HSP 1978) multiplied by a conservative 76% occupancy rate for the area (Kenner Hospital: Staff Review, 8/11/77) and the $170 per day estimate of hospital expenses for the NOA/BR area (AHA Guide,

Our problems do not end with those graphic statistics. The infamous F. Edward Hebert Naval Hospital which received attention on CBS' "Sixty Minutes" has a capacity of 250 beds with a present occupancy rate of 35 patients per day. That hospital sits in the middle of our planning region and again demonstrates the cost of unneeded institutional beds.

To exemplify our inability to achieve the goals of equal access set forth in 93-641, four New Orleans hospitals have received letters of findings from the Office of Civil Rights of the Department of Health, Education and Welfare charging them with racial discrimination. Three other hospitals are presently under investigation.

Half of the citizens of New Orleans are black. Despite having 18 hospitals in New Orleans, only Charity, the large state-run hospital, and Flint Goodridge, a black institution, and Touro Hospitals service blacks in significant numbers. For an example of the inaccessibility of health service in these institutions, statistics from the July 9, 1977 HEW Office of Civil Rights letters of findings reveal that in 1974, Hotel Dieu Hospital served nearly 9,000 patients with only 711 or 8.1% of those being black. This hospital served only 151 medicaid patients in 1974 despite the fact that it sits in the middle of New Orleans, a city with an enormous unemployment rate and 85,000 persons participating in the Medicaid program each month. Baptist Hospital, which served over 20,000 patients in 1974,

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3/ (continued)

Issue 1977) by 365 days per year.

8130 non-Federal beds
1183 Federal beds
9313 Short-term general hospital beds
x.24 Non-occupancy rate
2235 Non-occupied beds per day

$170 per day x 365 days = $62,050 per year

2235 beds/day x $62,050/day = $138,681,750 per year

served only 517 black persons. This constitutes 2.8% of their patient load. Only 90 medicaid patients were served in the Baptist Hospital in 1974. Incidently, both Hotel Dieu and Baptist Hospitals lie in predominately poor and black neighborhoods.

The poor whites participating in Medicaid receive their hospital services, as do poor blacks, from Charity Hospital. This hospital sees over 1200 patients per day in its 4 emergency rooms in downtown New Orleans. Health systems agencies, if they are to achieve the goal of equal access and quality care must (1) become sensitive to the existence of such over-burdened insitutions and (2) must avoid construction of more such public facilities since they perpetuate the existence of a dual medical system.

Health systems agencies can make a difference. The goals of equal access and cost containment are achievable. But, they will remain unattainable as long as HSA boards are chosen and operate as does mine.

Our health systems agency probably typifies most in that the Board of Directors is self-selecting, self-perpetuating, and unaccountable to anyone. That statement is not totally correct, for most providers are accountable to the respective provider institutions. However, few if any of our 39 consumer members are accountable to anyone. None are selected from or by any low-income persons.

To attain board membership, a prospective member must pass the scrutiny of the nominating committee. To date, only a handful of low-income persons or their advocates have passed that scrutiny to be seated on our 75 member board which contains 39 consumer members. My ability to gain board status had nothing to do with my commitment to equal access and cost containment, goals with which the

nominating committee was not concerned, but was the consequence of my status as chairperson of the Drug Abuse Advisory Council of New Orleans.

Our nominating committee went through great pains to assure that the board of directors and executive committee reflected the mandates of Pub. L. 93-641 as it related to geographic and racial considerations in the governing body composition. However, despite the fact that economic status lies in the same sentence of that very same law[4] little attention was addressed to that most important characteristic. A Bureau of Social Science Reseach study of the 1976 family income distribution of the population of HSA I in Louisiana revealed that 32.2% of all families in our area had incomes of less than $10,620, while 53.4% had incomes of less than $15,929. Despite the fact that about half of the families living in our planning area have incomes of less than $15,000, only 20% of the consumer board had family incomes of less than $15,000. More importantly, the executive committee which makes most of the important HSA decision, contained only 1 consumer board member with an income of less than $15,000 of its total 13 consumer members. That constitutes less than 8% of the consumer board. The intolerable situation exemplied by these statistics led to litigation.[5] At a deposition in that case the nominating committee

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4/ 42 U.S.C. §3001-1(b)(3)(C)(i)

5/ The Louisiana Association for Community Organizations Now v. New Orleans Area/Bayou Rivers Health Systems Agency and Joseph Califano, Civil Action No. 77-361, Section E filed 2-24-77, United States District Court, Eastern District of Louisiana.

chairperson stated that "the only members of the board who represent anybody are providers, who represent a constituency. That is the only one that, you know that I can remember that has ever purported to represent someone."[6]

Subsequent to the filing of this lawsuit, the board, in a knee jerk reaction, seated seven low-income consumer board members. None were seated on the executive committee. The board planned to seat several more. The task of identifying those low-income persons was assigned to me, as chairperson of an ad hoc committee on low-income persons. My job was incomplete when the devastating decision of the Fifth Circuit Court ofAppeals in ACORN v. Texas Area 5 Health Systems Agency, Inc.[7] was rendered and, with the pressure off,the board refused to nominate any additional low-income persons. I am convinced that no additional low-income persons will be seated on the board of directors of my health systems agency unless this Congress and HEW forced boards such as mine to adhere to the spirit and the letter of 93-641.

My experiences have convinced me that better decision will be made by health systems agencies like mine if more low-income people sit on our boards and more importantly our executive committee. Bad decision have been made and will continue to be made by boards such as mine that are not representative of the low-income community that we should be serving.

6/ Deposition of Ms. Willie Halpren, April 7, 1977, p. 56.

7/ Opinion, Fifth Circuit, 1977, 559 F.2d 1019, rehearing denied January 6, 1978.

Poor people have special needs. They constitute the medically underserved population and consequently have unique health problems. They need special protection and seek the right to protect themselves; to represent themselves or choose the representatives in numerical strengths in proportion to their numbers in the population.

An example of a poor decision that was made by our health systems agency is the approval of the building of the Kenner Memorial Hospital. The Kenner Memorial Hospital application was filed with our health systems agency on July 18, 1977 pursuant to section 1122 of the Social Security Act. This proposal called for the building of a new 100 bed general acute care hospital in a suburb of already overbedded New Orleans. This hospital is to be financed by non-taxable first mortgage revenue bonds, with a total cost of over $19,000,000. This applicant sought to justify construction of this unneeded facility by alleging that the nearby New Orleans International Airport and nearby petroleum plants (might) be the scene of disasters justifying such facility. The application admitted that the facility had overlapping services with two nearby hospitals but asserted that the service area would have a 195 bed shortage by 1980. Our HSA staff projected a somewhat different conclusion, stating that by 1980 the service area would contain more than 1900 excess beds. This, combined with their commitment to avoid unnecessary duplication of services, the critical shortage of professional personnel in the area, and our HSA's commitment to cost containment, led our staff to recommend disapproval without using the additional justification that this hospital would deny the poor equal access.

Our board reversed that decision. Approval was granted. The board meeting displayed how badly consituted boards make poor decisions. This hospital would not benefit poor people. Construction would be financed through non-taxable revenue bonds which had ramifications:

1. No Hill-Burton free service obligation would attach thus no benefit there for poor people;

2. Nor did the hospital have to comply with the Hill-Burton community service regulations forcing the hospital to treat Medicaid patients.

This makes little difference in reality, because doctors admit patients to hospitals and since doctors in our area do not admit Medicaid patients in substantial numbers to any hospitals except Charity and two other hospitals, the poor would still be denied access even if the Hill-Burton requirement attached.

Only one poor person sat on our 25 member executive committee at this application hearing. The presentation of the application included supportive testimony by all state and local elected officials from the area and the lobbying effort was intense. Some non-low income consumers were vulnerable to this pressure because of existing fiscal dependency on state and local governmental funding sources. Additionally, other private sector board members felt pressure because in our state, government is a major purchaser and could affect their very livelihood. The president of the board, a consumer, recused himself from voting but conducted the meeting (a member of his family owned stock in the applicant's management corporation). I perceived that these board members felt

threatened that the governmental officials would take financial and other sanctions against them. No other justification for their votes was possible. The institution was unneeded, the application was substandard and at times a bit ridiculous, and their statistical basis poorly documented. The economic composition of the board made all the difference. The board had no insulation from the pressure, implicit and sometimes explicit economic pressure. Surely a better decision could have been made by low income persons who could recognize that this hospital would not benefit them, would not benefit cost containment and thus, was an unneeded institution. A self-perpetuating, self-selected and non-accountable board had no one to account to when they made such a poor decision. Unlike yourselves, these board members are not accountable to the community at large and have no reason to fear consequences from decisions which are harmful to the community.

In a few days the board will consider the application of West Jefferson Hospital. West Jefferson lies in the suburb of New Orleans. This application seeks approval for a $35 million expansion. West Jefferson is presently under investigation by the Office of Civil Rights for racial discrimination. In 1974 West Jefferson admitted over 16,000 patients including 1562 black patients. This constituted 9.7% of the patient load. Only 286 of those persons were Medicaid patients. I understand that their black patient load has increased insignificantly to about 12% but this is obviously unacceptable in light of the fact that the 1970 census reveals 27% of the service area is black.

None of the staff review or committee meetings have broached these charges of race discrimination. It seems absurd that our HSA can make a final decision, which I predict will be approval, prior to the completion of HEW's civil rights review. But that is just what will happen. Our HSA does not collect adequate racial data. More importantly, it does not know its obligation under Title VI of the 1964 Civil Rights Act despite signing an assurance of compliance. HEW has not addressed this most important area, and if clarification was forthcoming, it could enable us to achieve our goal of equal access and compliance with Title VI.

I've consistently referred to Medicaid statistics. They have great relevance since in Louisiana approximately 80% of all persons participating in the Medicaid program are black. Thus, denial of access to Medicaid patients constitutes both denial based on race and economic status and is prohibited by the Planning Act and Title VI. More clarification of the HSA's role in assuring compliance with Title VI of the 1964 Civil Rights Act is needed. This should be achieved either through an amendment to the Act or through new HEW Title VI regulations.

Our HSA will continue to make decisions such as those that were made on the Kenner and West Jefferson Hospital applications until the board and executive committee are more reflective of the community they purport to represent. If poor people are to be adequately represented on HSA governing bodies, self-selection, self-perpetuation and non-accountability must be outlawed. I endorse both the House and Senate proposed amendments that would prohibit self-selection

but am concerned, from my own experience, that as long as nominating committees retain their absolute power, little change will result. Therefore, I request this Congress amend the Act to prohibit nominating committees from limiting the number of nominees that the public or members of the HSA can vote on, and be denied the right to propose a single slate of candidates. The nominating committee's powers should be limited, by law, to soliciting nominations and placing those eligible nominees in slots to enable the HSA to meet the governing body requirements.

Additionally, further clarification of our duty under the civil rights statutes must be accomplished.

I am encouraged by the proposed amendment to section 1534(c)(2)[8] that mandates that the backup centers for health planning develop and utilize methodologies for the education of new board members and staff and continuing education of board members and staffs of HSAs and state agencies. But, you must amend this law to provide that each HSA has a staff of professionals to train consumers like myself, who are lay persons and are often overwhelmed by this whole planning process. Our technical staff should be separate from that granted to providers to assure autonomy.

Accomplishment of these objectives will do much to assist HSAs in their efforts to achieve equal access and cost containment.

8/ Amending 42 U.S.C. § 300n-3(c)(2).

My name is Daniel S. Blumenthal. I am a physician on the faculty of the Emory University School of Medicine. However, I am not representing Emory University in this testimony and the views expressed here do not represent, necessarily, those of the university.

I am representing the Community Health and Monitoring Project (CHAMP), a citizens' group which has been active in the Atlanta area for about a year and a half. We would like to point out some flaws in the National Health Planning and Development Act as we have seen them at the local level and to cite examples of how these flaws have affected the operation of our own local Health Systems Agency. The problems I will discuss are:

1. Lack of a mandated democratic procedure for electing representatives to the HSA Board of Directors. This results in a Board which has no accountability to its constituents.

2. Lack of meaningful opportunity for consumers to participate in the HSA decision-making processes.

Board Selection Procedures

CHAMP was founded as an organization which would monitor our local HSA and attempt to have some impact on its policies and decisions. It was organized largely out of a sense of frustration felt by a number of citizens, both providers and consumers, who were concerned with the existing health-care system and its inadequacies. Our frustration was the result of a realization that the Health Systems Agency had the potential to have a profound effect on the health care system but that we, as ordinary citizens, had little or no opportunity to provide meaningful input to the HSA's decision-making process. We had absolutely no voice in selecting its board members and therefore had no real representative on the HSA to whom we could turn.

The board of our HSA, like that of many others across the country, was selected by a process that allowed for maximum input from organized provider groups and no effective input from ordinary citizens. In the case of our local HSA--the North Central Georgia Health Systems Agency—the local Regional Medical Program helped assemble a "blue ribbon committee" which included representatives of the major provider organizations. This committee solicited nominations for the HSA Board from civic organizations and agencies as well as provider groups and actually received over 600 nominations. It then largely ignored this collection of nominations and selected 30 of its own 45 members to the 63-member Board of Directors (the Board was subsequently enlarged to 69 members).

The bylaws of the North Central Georgia HSA established that new Board members, or those up for re-election, are chosen by the sitting members of the Board. The Board of Directors is thus self-selected and self-perpetuating. Not only is the board self-perpetuating but the single slate of nominees which the board votes on and invariably approves is prepared by a small nominating committee which is appointed by the President of the HSA. This committee has found it easy to repeatedly exclude consumer nominees in favor of nominees of the medical society. It should be added that, in theory, every citizen over the age of 17 who lives in the North Central Georgia area is a "member"of the corporation which is the HSA. The membership, however, has no vote in choosing the corporation's board.

The Board of the NCG-HSA contains sufficient consumers to meet the guidelines established by PL93-641. However, of the 37 consumers on the original board, 2 were nominated by the State Nurses Association, one by the District Pharmacy Association, 6 by local hospitals, and 24 by local medical societies. It seems evident that many consumer members of the Board must feel that their allegiances lie with those who put them on the Board and those who can keep them there: the providers.

It must also be pointed out that some consumer members of the original board had consumer credentials which were doubtful at best. Three were or have recently been board members of local hospitals or nursing homes. Another was a psychologist. Two others were morticians who had conducted ambulance services in the recent past. One owned a drug store. At least 4 were connected with insurance sales. Four were on the boards of local banks. Seventeen were connected to voluntary organizations which receive and distribute health funds (there has been some turnover in Board membership since this analysis was done. Information on the background of Board members, however, is no longer as easy to obtain from the HSA as it was previously). Not only is it evident that HEW does not have the desire or data to take corrective action to enforce clear provisions of the law, our experience is that HEW is much, much more responsive to the HSAs, and the medical profession which runs them, than to consumers who are trying to bring about common sense, cost-containing health care planning.

This was the source of the frustration that led us to organize CHAMP: the knowledge that we, as citizens who were not members of powerful provider organizations, had no representation on the Health Systems Agency.

How does provider control of an HSA affect its function? An example from our local HSA may illustrate. An HSA's power, as you know, is chiefly negative; that is, the HSA may deny institutions or agencies the right to spend money on projects which are not commensurate with priorities established by the HSA. It is also widely agreed that health-care inflation has been fueled in large part by the tendency of hospitals to overbuild and to purchase expensive duplicative equipment. This is particularly true in the North Central Georgia area, where there are some 2500 excess hospital beds. In the Atlanta metro area alone, there are 14 cardiac catheterization labs in place or under construction, and 15 CAT scanners.

An HSA could, therefore, move to control health care costs by refusing to approve further investment in hospital facilities; it could suggest to the hospitals

proposing such expenditures that the money could be better invested in needed primary care projects, such as satellite clinics in rural areas. Tables 1 and 2, attached, show the recent performance of the North Central Georgia HSA on this issue. Since April, 1977, the agency has approved 15 projects relating to inpatient care at 12 different hospitals; these projects have totalled over $30 million. During this same period, the NCG-HSA has rejected only 2 projects, totalling $866,400. It is evident that the provider-controlled board is reluctant to reject requests made of it by its provider colleagues who administer hospitals.

The conclusion is clear: in the area of cost-containment, particularly as it pertains to hospital costs, the NCG-HSA has had little impact. I would suggest that any HSA controlled by providers will not be likely to wreak major changes in the health care system it helped create.

Provider control is not a circumstance unique to the North Central Georgia HSA; it is, rather, common to many HSAs in the South and throughout the country. It is clear that, in a situation in which Board members are appointed by committee rather than elected by a democratic process, organized provider groups are essentially able to appoint their own representatives. Consumers have no similar power.

Other Obstacles to Consumer Participation

In addition to lacking representation on HSA boards, consumers experience other difficulties in gaining a voice in the formulation of changes in the health care delivery system. Foremost among these difficulties is a lack of opportunity to gain an understanding of the issues and processes involved. The health systems agencies are part of a complex structure that includes HSAs, SHPDAs, SHCCs, HSPs, AIPs, CON laws, and various other varieties of "alphabet soup." The average citizen, even if he or she has heard of HSAs, has little or no comprehension of the total structure of which the HSA is a part. Nor does the average citizen, in many cases, understand the issues

with which the HSA must deal. There is little community appreciation of the fact, for instance, that overbuilding of hospitals is a major contributor to health care inflation, or that medical postgraduate training programs have a major influence on the distribution, or maldistribution, of physicians.

There has been little attempt on the part of the HSAs to educate the community on these issues. Wihtout this sort of "patient education," there can be little meaningful consumer input to the deliberations of the HSA. We at CHAMP have attempted to educate the people we reach, but our resources are very limited.

In the North Central Georgia area, our HSA has actively solicited consumer viewpoints on health care needs through a variety of open hearings. The NCG-HSA has, however, made it difficult for informed citizens to participate in HSA processes and procedures by such devices as making it hard to obtain committee reports or staff project analyses. There has been little attempt made at educating the public on HSA procedures or on the issues involved.

As an initial recommendation in this area, we feel that it would be helpful if the "alphabet soup"—that is, the health planning process—could be simplified. In any event, we feel it imperative that community education be made a priority for the HSAs and that they be funded for this purpose. The education should be directed at the health planning process as well as at the issues involved in that process.

The exclusion of the public from the HSA process is part, we feel, of the general trend toward the HSA becoming a sort of private club whose membership selects itself, as at any country club, and whose committees and decision-makers will listen patiently to outsiders who do not really understand the workings of the club but will not include those outsiders in the club's activites or seriously consider their proposals.

Conclusion

The Community Health and monitoring Project, then, has two major recommendations on modifications of PL93-641:

1. It is imperative that provisions be established which would require HSA board members to be chosen by a democratic electoral process.

2. HSAs should be required to engage in public education efforts and to solicit the participation of the public in HSA decision-making procedures.

TABLE 1. HOSPITAL INPATIENT PROJECTS APPROVED BY N. CENTRAL GA. HSA
APRIL 1977- JAN 1978

Type of Project	Hospital		Amount
ICU-CCU	Villa Rica		$140,000
Renal Dialysis	Piedmont		60,000
Construction, Renovation	Coweta		900,000
	Brawner		1,098,837
	Egleston		25,912,358
		subtotal	27,111,195
X-ray equipment	Smyrna		168,800
	Grady		117,850
	Cobb		144,000
		subtotal	431,500
Air Conditioning	DeKalb		218,000
	Grady		160,000
	Northside		226,648
		subtotal	604,648
Televisions	W. Ga. Med. Ctr.		120,000
Cardiac Cath Lab	Piedmont		667,115
	Kennestone		350,000
		subtotal	1,017,115
Laboratory	Piedmont		150,000
TOTAL			$30,434,458

TABLE 2. HOSPITAL INPATIENT PROJECTS PROJECTS DISAPPROVED BY N.CENTRAL GA. HSA
APRIL 1977-JAN 1978

Type of Project	Hospital	Amount
Radiation Therapy	DeKalb	$746,400
Cardiac Cath Lab	Cobb	120,000
TOTAL		$866,400

Mr. Chairman, members of the subcommittee, my name is Willie Mitchell. I am 57 years old and have had health problems most of my life and am now disabled. I was born and raised in Coweta County, Georgia, where my parents were sharecroppers. I now live in Newnan, Georgia, which has a population of about 13,000.

I've been in the Army, I've been a welder, and I've worked in the South Georgia shipyards. I've been active in community affairs all my life—I've been elected and appointed to several positions as a representative of my community, including election as an elected alternate delegate to the 1972 Democratic Convention.

So, I know something about politics, especially the politics of providing services to poor people. I know about the value of public participation in these politics—I know it is the key to making these programs work and making them accountable in their communities. Public participation and accountability is the only way administrators of federal programs find out what people's real needs are and make sure such programs address those needs. Opportunities for advisory input are fine, but those alone are not enough, especially where the people running the programs are not inclined or bound to act on what they hear. And the only way to insure that the programs will be responsive, accountable and make correct decisions is to give people effected by the programs, and for whom the programs are designed, the power to make or at least share in those decisions.

My concern for effective health care planning is very personal. I have arthritis, and a heart condition, and I am diabetic; my wife had a stroke a year ago, and has hypertension. So I have become very aware of high health care costs that seem to keep going up. I have also become very aware of access problems; poor people, more than anyone else, are the victims of the lack of medical facilities in rural areas. When I or my neighbors need medical care we must not only locate doctors and hospitals, we must also find the ones who will accept Medicaid or Medicare, partial payments, or

lower payments. Some counties in Georgia have no hospital. In my county there are two hospitals but only one serves black people. I often carry family and friends to doctors and hospitals and often have to go to two, three, or four places to find someone willing to provide treatment. I know all too well what it's like to be looking for a doctor or hospital and to be turned away because we can't pay. Often by the time we can find treatment, the patient's condition has worsened. And even worse, sometimes when a hospital finally admits you, they won't release you until you pay. I have affidavits from home here, which show that it is a common practice to demand payment prior to release. In fact, we are often forced to sign promissory notes before we can get out of hospitals, or get our children out of hospitals.

HSAs have not been responsive to these needs at all and have made it difficult, if not impossible, to get involved in their decision-making. My HSA has had public meetings in Newnan only twice since it was established. The HSA went through the motions of notifying the public of the meetings, but no real, effective effort was made to obtain real community input. It is obvious that providers control the HSAs and are making, and will continue to make decisions that ignore the needs of our community. And because of the way the board members are chosen, we have no hope that things will improve. The President of the board chooses a committee which nominates the new board members, and this slate of nominees is approved by the board. Nominations from the public are ignored and most consumer nominees who get elected are nominated by providers. This shuts off access to the board by my community and allows providers to go on making the same decisions they've always made—decisions which ignore the cost of health care and ignore the problems of access to that care.

Nor has the HSA done anything to educate us about health care or health planning so that we can become more aware of what needs to be done and what we can do. Poor people are aware; we may not be book-wise, but we are experience-wise. A lot of talent in the poor communities is being overlooked.

A good example of what happens when poor people are kept out of decision-making came up last year when the Project Review Committee of my HSA had to consider a proposal for renovation funds for Newnan Hospital, one of the two hospitals in my county. The other county hospital, Coweta General, had also asked for approval for renovation funds in about one-third the amount of Newnan Hospital's request, and the committee was to pass on both requests. Coweta General serves the total community. Newnan Hospital, on the other hand, does not accept Medicaid or Medicare patients, it has not filed a Civil Rights compliance form, and is known by all as a hospital that treats only white people. (I have attached clippings and documents that confirm this practice.) As the HEW representative who sat in on the committee meeting put it, Newnan Hospital serves only "certain members of the community 'by tradition.'" Coweta General's request was approved, but despite what I have told you, the HSA Committee did not see fit to come down with a vote of disapproval on Newnan Hospital's request. By its vote the committee gave HSA endorsement to racism in health care. This could not have happened if poor people had been included in the HSA's decision-making structure.

It is important that the public, particularly the poor, really become involved in a meaningful way in HSAs. Congress intended that they have a right to such participation, but the providers have been able to ignore this. To me this means either the Act was meant to keep providers in power or the Act has not been enforced. Congress must do something to insure the participation of poor people in programs that are meant for them, and to give us the right to represent ourselves, not to have others decide what we need or make decisions for us.

Let us represent ourselves. We are the people most unable to pay medical bills; we are more concerned than anyone else about keeping health care costs down, and seeing that medical facilities are available for all.

Times-Herald

Newnan, Georgia — Thursday, June 9, 1977

Public Hearing Is Scheduled For Conflicting Hospital Projects

A $2.9 million renovation project at Newnan Hospital may jeopardize a similar project planned by Coweta General Hospital.

The conflicting building projects of both hospitals will be aired openly at a public meeting tonight in Atlanta.

The issue has been made public with both hospitals' desire to make certain renovations. Newnan Hospital wants to make $2,929,650 worth of renovations and Coweta General wants to make $900,000 worth of renovations.

There is a federal law which states that health care facilities (including hospitals, nursing homes, etc.) must get state approval for expansions and/or renovations. The law affects only those institutions which receive federal money including Medicare and Medicaid.

An agency has been formed to help administer the law: the Health Services Agency (HSA). There are 24 counties in the area covered by the HSA of which Coweta county is a part.

The purpose of the law is to prevent duplicated services. When there are duplicated services, more hospital beds are vacant and hospital costs (and insurance premiums) go up for patients.

Projects

Coweta General wants to construct, renovate and modernize several areas of the hospital by closing three intensive care areas and building one new intensive care area; by renovating a 20-bed patient care unit; by enlarging the physical therapy area; by renovating the nursery area and through renovation establish a new pediatric care unit. The project is to be funded by a federal grant.

Newnan Hospital's project is for renovation and new construction to improve the existing facility. It is planned to change the usage of several old buildings and add on new patient rooms, diagnostic and treatment space, as well as office and related spaces. The project is to be financed with first mortgage bonds (which have already been sold), cash on hand and contributions.

If the plans of both hospitals are approved, there will be more duplicated services in Coweta county. Hospital insurance premiums are already relatively high in Coweta county.

Newnan Hospital is a private institution and accepts no Medicare or Medicaid patients. Although the hospital states, "We admit patients regardless of race, creed, sex or national origin," black people are not treated at the private facility. HSA officials say, "To our knowledge, this is the only facility in the state of Georgia of its kind (in relation to admission policies)."

Coweta General Hospital is a publicly-owned hospital, supported by tax money. It accepts all patients. Right now, Coweta county is putting about $150,000 per year into the hospital budget to supplement Medicare, Medicaid, etc.

If Newnan Hospital is improved with renovations, more white patients who are able to pay for health care may go to Newnan Hospital. Therefore, more beds may be vacant at Coweta General Hospital and the costs may go up — as will the amount of tax money needed to supplement the hospital.

If Coweta General is improved with renovations, there is a chance that some white patients who now patronize Newnan Hospital will go to Coweta General instead, leaving Newnan Hospital with empty beds. Then costs at Newnan Hospital will increase.

ATTACHMENT

to testimony of Willie Mitchell

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Bob Youngerman, Executive Director of the North Central Georgia HSA (which includes Coweta county), and Betty Whisenant, Chairman of the HSA Review Committee, met with the Coweta General Hospital Authority Tuesday at Coweta General Hospital.

Youngerman said, "The HSA is geared to good planning. It has been proven that empty beds drive prices up and under - utilization tends to cause costs to rise. We prefer to have local folks solve their own problems (of planning) locally."

He said he had tried to get Newnan Hospital officials and Coweta General officials to meet together on the present planning problem. Coweta General agreed to meet; however, Newnan Hospital declined. So the meetings were held separately.

Because of the lack of local cooperation, the preliminary staff analysis of the HSA has called for denial of both applications or approval of both applications in an attempt to force the two hospitals to plan together.

Ewing Barnett, Administrator at Coweta General, declared, "Newnan Hospital submitted its plan 'coincidentally' at the same time Coweta General submitted its plan. Newnan Hospital did not have any real reason to submit the plan to HSA (since Newnan does not need approved to go ahead with the project).

Barnett charged that Newnan Hospital may have submitted the plans to HSA "to block Coweta General's" application for approval. "Coweta General is the only one that can be injured by denial. Newnan Hospital has already sold the bonds and is going to go ahead with the project. All this is doing is perpetuating the circumstances that have existed here since 1962 (when Coweta General was opened)."

Barnett continued, saying that Coweta General has "tried for years" to cooperate with Newnan Hospital in planning, but "I don't believe there is a desire for Newnan Hospital to plan with Coweta General. If you (HSA) approve both plans you deny the policies of good planning. If you deny both plans, Newnan Hospital is going to do it anyway."

He further charged, "Newnan Hospital has no desire to serve the people. Thirty-seven per cent of Coweta county is black. Twelve per cent is over 65 years old and 10 per cent are Medicaid patients. That's a big whopping percentage of this county, and they don't darken the door at Newnan Hospital. We live with it and we do our best, but the situation lends itself to duplication. When the Review Committee meets, it is my hope that the projects will stand separately."

Youngerman, in answering the question, said that Coweta General's plan would probably have been approved as "routine" if Newnan Hospital had not submitted its plan. He said that HSA believes some of the services at Coweta General and Newnan Hospital should be combined (the obsetrics unit, the pediatric unit and the emergency room). "The census of these units is low at both hospitals. There must be joint planning. The way things are coming down the pike (in federal laws), Newnan Hospital cannot exist forever serving a select clientele."

Youngerman further stated, "Private hospitals allege that planning agencies (such as HSA) have bias in favor of county hospitals and against private hospitals. That is not the case. Denial of these two projects may be an incentive for the hospitals to work together. Approval of one would be open to charges of favoritism."

If the HSA refused to consider Newnan Hospital's plan, it would be considered the same as an approval of the plan, according to the law.

Coweta County Commission Chairman Johnny Brown commented, "How can it be considered duplication of services by the HSA? If a black person needs health care, he can't go to Newnan Hospital to get it. And if there is some special kind of care which Coweta General cannot give because of denial of this plan, where does this black person go for this care? It doesn't matter for him if Newnan Hospital has it or not."

Newnan Hospital's Reply

William Baxter, Administrator of Newnan Hospital, told the Times-Herald Wednesday that as far as Newnan Hospital is concerned, there is and has not been any lack of cooperation with Coweta General. "Our plans for expansion and renovation have been in the works since the early 1970's," he stated. The plans were made public at that time; however, the economy of the times made it impossible to carry them out and the project was postponed.

"Last February our board of directors re-activated the original plans with the addition of provisions for new services which have been instituted since that time. In September of 1976 our board of directors entered into an agreement with Hospital Building and Equipment Company in St. Louis, Mo., to design and draw up the specifications for the necessary renovation, provided that we could secure the necessary money."

my board would be so uncouth as to try to stop Coweta General Hospital from getting anything. We do not know what the future holds. We could all be under National Health Insurance in the future, as well as President Carter's "CAPS" (which will provide no reimbursement from the federal government for capital improvements if not proven an allowable expense). It is for this reason that we submitted our application to the HSA for approval. We wanted to be absolutely above-board and go through the proper state process in order to protect our patients."

Baxter said that he has always assured HSA that he or members of the hospital board would be glad to meet to discuss Newnan Hospital's application.

Public Hearing

A public hearing on both plans will be held tonight (Thursday) at 7:30 in the Red Carpet Conference Room (Suite 806) at 1447 Peachtree Street, N. E., in Atlanta. The review Committee will consider the plans at that time.

A second public hearing will be held June 14 at the same place before the Executive Committee of the HSA. The final decision will be made by the State Comprehensive Health Planning Agency this month.

UNITED STATES GOVERNMENT

Memorandum

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION IV — ATLANTA

TO : Files

DATE: June 22, 1977

FROM : Cathy Spivey-Paul

REFER TO 04-P.000219-02-0

SUBJECT : Trip Report - North Central Georgia Health Systems Agency, Inc.
Atlanta, Georgia
Date of Visit - June 9, 1977

Purpose of Visit: Observation of Review Committee Meeting (Agenda attached)

Persons Seen: HSA Staff, HSA Review Committee

Work Performed: Observation of the North Central Georgia HSA Review Committee and its procedures for Project Review

Several controversial reviews were conducted by the HSA Review Committee including competing applications between the Coweta General Hospital and the Newnan Hospital, both located in Newnan, Georgia and both applying for renovation and modernization. There was much discussion concerning these two facilities. Coweta General Hospital is a county owned facility which serves the total community population, including Medicare, Medicaid, etc. Newnan Hospital, on the other hand, is a private non-profit hospital which serves certain members of the community "by tradition". The HSA appeared to be instrumental through its review process in getting these two institutions (which are located directly across from each other) to meet and attempt to reconcile their differences of the past and attempt to coordinate and consolidate their planning efforts in order to eliminate duplicative services. The Federal Representative was involved in the discussion in order to provide clarification concerning the process under Section 1122 Reviews, since it was revealed that the Newnan Hospital apparently had a "lack of timely notice". The HSA was advised that they should review and comment relative to the need for the proposed Section 1122 expenditures and that the secretary, considering the recommendation of the local planning agency and the state designated planning agency, would make a determination concerning whether the circumstances of the lack of timely notice would or would not preclude reimbursement.

Criteria for the Review of free standing ambulatory-surgical facilities was also discussed by the Review Committee since such an application was pending their review. Since the Committee determined that they did not

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HELP ELIMINATE WASTE COST REDUCTION PROGRAM

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yet have enough information available to adequately formualte review criteria for this specialized service, the Review Committee recommended that the pending application be declined by the HSA for review purposes at this time.

Recommended Follow-up: The Newnan Hospital representatives indicated that they would be in touch with the HEW representatives concerning their Section 1122 lack of timely notice.

REVIEW COMMITTEE MEETING

SUMMARY OF PROCEEDINGS

Red Carpet Conference Room
Kennesaw Life Building

June 9, 1977
7:30 P.M.

PRESENT

Gerald Bishop
Betty Whisenant, M.N.
Ewing Barnett
Fred Higginbotham
Audrey Horne
Herbert Mabry
Rep. Sidney Marcus
Jo'Ann McClinton
Paula Bicknell, R.N.
Joseph Smith
Lawrence Freeman, M.D.
Jim Kelley, Legal Counsel

ABSENT

Ken Thigpen
Wilma Shelnutt

ALSO PRESENT

STAFF

Joe Taylor
N. R. Balthrop
Gerry Mills
James Cobb
Troy Cox
Susan Haskell
Freeman Vaughn
Raymond McQueen
Doris Metzler

VISITORS

C. E. Brasch
Ellis Crook
Luke Barclay
John Stone, M.D.

VISITORS (cont'd)

D. E. Miller
Mark A. Gould, M.D.
W. H. Hightower, Jr.
J. E. Cammon
A. H. Barron
J. J. Thomasson, Jr., M.D.
John R. Gerlack
Douglas L. Buckner
William C. Baxter
Thomas H. Braswell
Calvin A. Bragy
Charles Eberhart
John Strother, Jr.
Cliff Goodman
Dr. Dan Bleumenthal
Marguerite Davis
Ebrahim M. Alsieni
Robert F. Thompson, M.D.
N. Seldon Brown
Glen Ware
David Hightower
Mr. Brooks
Dennis Herendeen
Kathy Spivey
Mr. Mozer
Mr. Fink
Mr. Ashford
Mrs. Ashford
John Hughes
Walt Hildon
Dick Bledsoe

1. CALL TO ORDER

The meeting was called to order by the Vice-Chairman, Mrs. Betty Whisenant, at 7:30 P.M.

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II. RECOGNITION OF VISITORS

The visitors were recognized and invited to participate at the appropriate time.

III. APPROVAL OF PROCEEDINGS OF MAY 12, 1977

The Summary of Committee Proceedings of the May 12, 1977 meeting were approved as mailed.

IV. ELECTION OF OFFICERS

Mrs. Betty Whisenant was nominated and unanimously elected to serve as committee chairman during the 1977-78 year.

Mr. Fred Higginbotham was nominated and unanimously elected to serve as vice-chairman during the 1977-78 year.

V. REVIEWS

Mrs. Whisenant reminded the Review Committee of the "Conflict of Interest Policy". Four committee members declared a conflict of interest and abstention on the following projects:

Lawrence Freeman, M.D. - Both DeKalb General Hospital Projects
Ewing Barnett - Newnan Hospital, Coweta General Hospital
Betty Whisenant - Brawner Hospital
Gerald Bishop - Covington Manor Lease

NON-SUBSTANTIVE REVIEWS

1. Federal Funds Review - Central DeKalb Mental Health Center - Continuation Grant
   Mrs. Bicknell gave the task force report supporting the center and by voice vote the project was unanimously approved.

2. GA 1462 - DeKalb General Hospital - Air Conditioning Equipment Replacement
   Mr. Doug Buckner spoke on behalf of the project pointing out its cost justification and by voice vote the project was approved.

3. Federal Funds Review - Georgia Regional Hospital - Atlanta - Training Grant
   Dr. Dennis Herendeen spoke on behalf of the project. The project was approved by a voice vote of ten to one.

4. Federal Funds Review - Emory University School of Medicine - Training Grant
   Dr. John Stone spoke on behalf of the project and by voice vote the project was unanimously approved.

SUBSTANTIVE REVIEWS

1. GA 1459 - Brawner Hospital - Renovation and Bed Replacement
   David Miller spoke on behalf of the project explaining that the 18 new patient rooms would replace 34 existing beds with no net gain in hospital bed size. Barbara Harvey of the HSA-Mental Health Task Force supported the

project. Mr. Miller explained that the hospital took Medicare patients but the State regulations prohibited them from receiving payment for Medicaid patients. He explained that the corporation netted about 5% of the revenue for profit and Doctor Mark Gould explained that the 17-day stay was not uncommon for the type patients seen in the facility. The vote was ten to zero for approval with one abstention.

2. GA 1455 and GA 1468 - Coweta General Hospital and Newnan Hospital - Renovation and Replacement. The chair recommended that both projects would be reviewed at the same time with separate vote being taken after presentation and discussion of the two projects. The committee agreed.

Ewing Barnett spoke on behalf of the Coweta General project. He stated that the ICU/CCU project had been approved last year (Project GA #1270) and the approval expired in June of 1977. He explained that EDA funds were promised and in December 1976 the NCG-HSA approved an expanded hospital project. At Georgia CHP office request, the project was scaled down and resubmitted as project #1455. He stated joint planning in the county had never materialized even though there was no opposition to joint planning by Coweta General Hospital.

Mr. James E. Cannon pointed out that Coweta General Hospital serves the total community while Newnan Hospital does not.

Bill Baxter spoke on behalf of the Newnan Hospital project giving the history of the hospital and pointing out what was included in the project. He emphasized that the hospital size was being reduced from 105 beds to 100 beds. Mrs. Whisenant asked why were they coming for review since they don't serve Medicare and Medicaid patients. Mr. Baxter replied that the future was unclear and if the Carter Administration Bill was passed they might not receive reimbursement for interest and depreciation expense. Mr. Mabry asked if the hospital accepted black patients. Mr. Baxter replied yes they are in compliance with the Civil Rights Act.

Mrs. Whisenant asked if they had signed form 441 "Assurance of Compliance" with the Civil Rights Act. Mr. Baxter answered yes. Joe Taylor reported on the HEW Office of Civil Rights telephone discussion with Mr. Lang which indicated that HEW has no record of Newnan Hospital signing form 441.

Mr. Baxter was asked if the first mortgage bonds had been sold. He answered that he hoped so. Mr. Baxter was asked if the hospital admitted black patients and he answered no one was refused admission. Joe Taylor explained the efforts to arrange a joint meeting between the hospitals which was reported on in the two analyses.

Mr. Baxter pointed out that the hospital did not accept federal funds and did not need 1122 approval, however, they did think they should go for review. He said the "Bond People" want them to get 1122 approval to help retire the debt. He felt the hospital would be harmed without approval.

Mr. Lindsey Barron, Newnan Hospital Board member insisted no patients would be refused because of race, creed, color or national origin and asked that both hospital projects be approved because of rapid population growth in the county.

Doctor Thomasson, Newnan Hospital surgeon asked for approval of both projects. He stated the Newnan Hospital Bonds had been sold now and they have already borrowed the money needed to go ahead. He said their 1122 application was filed in order to be above board and to be prepared for changing Federal laws. Mr. Smith asked Doctor Thomasson if he ever admitted black patients to Newnan Hospital. Doctor Thomasson replied no because black patients would rather be at Coweta General Hospital where the rest of the black patients are treated.

At this point Jim Kelley, HSA legal counsel, interrupted to point out that under 1122 regulations, a 60 day notice is required before an obligation for capital expenditure is incurred. The expense in connection with the sale of bonds is a capital expenditure and consequently the Review Committee cannot recommend 1122 approval because of the obvious lack of "Timely Notice".

Dr. John Wells, Chief of Staff of Coweta General Hospital pointed out since the bonds have been sold and the money is on hand, Newnan Hospital would go ahead. Coweta General needs approval and he asked the committee to please vote for the Coweta General Hospital project.

Jim Kelley asked Mr. Baxter if the Newnan Hospital had obligated their funds. Mr. Baxter replied yes, they had obligated a portion of their funds. Mr. Kelley pointed out that the Secretary of HEW would make the determination on "Timely Notice". Kathy Spivey from HEW Region IV office pointed out that the committee would recommend to the State of Georgia and the State would recommend to the Secretary of HEW, then HEW would call on the applicant for additional information in order to determine if there is a lack of "Timely Notice".

Ewing Barnett pointed out that Coweta General Hospital had to have 1122 approval by July 10, 1977 in order to be eligible for EDA funds. (Public Works Act of 1976)

Bill Baxter asked if the committee could recommend favorably on feasibility, need, and cost. Mr. Kelley answered yes but this could not be construed as 1122 approval.

Mr. Bishop moved that the vote on the two projects be separate. The motion passed unanimously.

Mr. Higginbotham called for the vote on both projects.

The vote on the Coweta General Hospital project was eight to two for approval with one abstention.

The vote on the Newnan Hospital project was five to five with one abstention.

3. GA 1463 - DeKalb General Hospital - Radiation Therapy project.
Jack Gerlack spoke on behalf of the DeKalb General Hospital project pointing out that the Linear Accelerator would replace an old 1961 model Cobalt unit, that there was a need for the equipment and it would solve a severe transportation problem for many of their patients. The vote was six to three in favor of the project with two abstentions.

4. GA 1464 - North Metro Medical Center - New 120 bed hospital.
Joe Taylor reported that Mr. George Desern had called at 2:10 P.M. this date to ask that this project be withdrawn without prejudice to be filed later. Mr. Desern stated that a formal letter making this request would follow.

5. GA 1456 - LaGrange Medcraft Nursing Home - Expansion project.
The staff pointed out there was no need for additional beds in the LaGrange area according to State of Georgia criteria. The vote was seven to two against approval with two abstentions.

6. GA 1467 - Progressive Health Care, Inc. - Lease of Covington Manor nursing Home
The staff pointed out that there is an excess of 2300 beds in the area and that leases should be reviewed as if they are new projects. Mr. Bishop pointed out that the lessor is a capable firm. The vote was six to three for approval with two abstentions.

VI. OTHER BUSINESS

Criteria Development for Free Standing Ambulatory Surgical Facilities

John Strother asked that a provision be added to the criteria that would exempt existing facilities or facilities under construction from the review process. He also pointed out that the Orkland Corporation had been commissioned to develop review criteria for HEW for such facilities. This study has just been released and he asked that reviews be delayed until good criteria can be developed.

Doctor Freeman moved that the development of FSASF review criteria be tabled until the next review committee meeting. The vote in favor of this motion was unanimous.

VII. ADJOURNMENT

The meeting adjourned at 12:15 A.M. by unanimous consent.

ATTACHMENT #1

STATEMENT OF COMMUNITY HEALTH AND MONITORING PROJECT
TO THE NORTH CENTRAL GEORGIA HSA EXECUTIVE COMMITTEE
JUNE 14, 1977

We are becoming increasingly concerned with the reluctance of the NCG-HSA Review Committee to treat critically the secondary and tertiary care hospital proposals submitted to it and to reject those which cannot be clearly justified. The projects reviewed last Thursday night illustrate this problem.

The first substantive project reviewed and approved was a proposal by the Brawner psychiatric hospital to enter into a 1.1 million dollar renovation. The chief benefit of this renovation appears to be the provision of each semi-private room with its own bath. The cost would be felt as an increase in the daily room charge of about $15. An increase of this magnitude does not appear to be justified for the benefit derived. The increase will ultimately, of course, be borne by everybody who pays health insurance premiums and social security taxes.

The review committee was next presented two hospital renovation projects for Coweta County with a total cost of nearly 4 million dollars. It is not clear that major expenditures on hospital renovation and construction for Coweta County can be justified at this time. Moreover, the larger of the two projects involved Newnan Hospital, an institution against which a charge of racial discrimination in admission policies was leveled by a black minister from Coweta County who traveled to Atlanta for the meeting because of his concern with this problem. The charge was not adequately answered. The hospital administrator maintained that Newnan Hospital "has had" blacks as patients, but could not remember when or how many. He stated that Newnan Hospital had filed a form 411 with the Office of Civil Rights, but when Mr. Taylor of the HSA staff pointed out that he had called the Office of Civil Rights and no such form had ever been filed, the administrator indicated that he did not know which federal forms he might have signed, stating only that "if they sent us one, we signed it."

Ultimately, the review committee vote on the Newnan Hospital project was tied 5-5, with one abstention. Although the HSA decision will not affect the hospital's commitment to build, since no federal monies are involved, the failure of the committee to reject the project in principle amounted to a failure by the committee to reject racism in health care.

Next, the committee approved the purchase of a $750,000 linear accelerator for DeKalb General Hospital. While this purchase will undoubtedly add to the prestige of the hospital, it is another very expensive acquisition which will not fill any pressing health-care delivery need in the Atlanta Metro area. It was pointed out at the meeting that 14 similar pieces of radiation-therapy equipment are in place or on order in this area.

A common thread runs through all these proposals: while it is shown in every case that the project will benefit the institution involved, it is not shown that the project will improve the state of community health-care delivery. In each case, the project will add appreciably to the overall cost of health care. None of the projects speaks to the more pressing need for additional primary-care services. It is difficult to justify such projects.

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We are also concerned with the increasing difficulty faced by concerned citizens in attempting to contribute to the deliberations of the NCG-HSA. Last month, we were informed that persons without a direct financial interest in the projects being discussed would be allowed to speak only before or after the Executive Committee meeting, but not during the deliberations. We also now find that staff analyses of the projects are no longer presented publicly at Review and Executive Committee meetings, but are contained in folders to which only committee members have access. It was also our understanding that important HSA meetings, such as Executive Committee meetings, were to be included in the weekly public meeting announcements in the Atlanta Journal-Constitution. This month's Executive Committee meeting was not so published.

Thank you for your consideration of these concerns.

Mr. Chairman, members of the subcommittee, my name is Wayne Pressel, and I am an attorney in private practice in Atlanta, Georgia. Until the first of this month, I was an attorney with Georgia Legal Services Programs and in that capacity was lead counsel in a case entitled, Rakestraw v. Califano. It is that case and the experience of consumer health interests in Georgia that I want to discuss with you today. While I support the efforts of this subcommittee to improve the Health Planning Act, unless there is a renewed commitment to reform the structure and operation of the Health Systems Agencies created under that Act so that consumer participation will be ensured, then the pursuit of cost-containment, consumer access to health planning, and quality health care is a meaningless endeavor.

The experience of consumer health interests in HSAs in Georgia has been a paradigm of abuse by provider interests. Where Congress had intended to create a mechanism for consumer access to health planning, the six Georgia HSAs[1/] were conceived of and are controlled by provider interests. Where the Planning Act had intended to secure fair representation of heretofore underrepresented groups such as low and moderate income persons and women, the Georgia HSAs were designed to exclude institutionally those interests from being heard much less represented. In short the pro-consumer provisions of the law have been politically repealed by those whose power it imperiled.

It is not surprising that this has occurred. The provider interests which have historically excluded consumer interests were organized once again to escape the threat to their unprecedented powers posed by Congress through the Planning Act. In Georgia the strong arm of the Medical Association of Georgia had been deeply involved

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1/ The North Central Georgia Health Systems Agency, the Southeast Georgia Health Systems Agency, the East Central Georgia Health Systems Agency, the Appalachian Georgia Health Systems Agency, the Central Georgia Health Systems Agency and the Southwest Georgia Health Systems Agency.

in the evolution of the statute and had carefully plotted the course of events. For example, five of the six original HSA directors were immediate former employees of the Georgia Regional Medical Program (GRMP), operated by the Medical Association of Georgia (MAG). Former staff persons of the GRMP found jobs on the newly formed HSAs. The North Central Georgia Health Systems Agency hired as its Executive Director, a former lobbyist for MAG, who in that capacity had lobbied against passage of the Planning Act. And the GRMP had orchestrated formation of steering committees which, in turn, became the HSAs. In the case of North Central Georgia HSA, for example, the GRMP ran the steering committee meeting at which nominations for the original HSA board were made. GRMP succeeded in systematically voting down nominations from outside the GRMP and in having most of its own nominees placed on the board (30 of the 63 board members were members of the GRMP Steering Committee). This story was repeated in formation of the other five Georgia HSAs as well, with provider-run steering committees quietly designing board memberships to the exclusion of the public. In the end all six Georgia HSAs had their consumer members specially chosen based on the member's provider orientation or health industry affiliation.

In 1976, when individuals and groups representing low and moderate income persons, women, the elderly and the handicapped first became aware of the existence of HSAs in Georgia, they were faced with these virtually impregnable provider-dominated organizations. To make matters worse, five of the six HSAs adopted systems for self-perpetuation whereby boards of firmly-entrenched providers and their specially chosen consumer counterparts selected their successors. Nominating committees appointed from the board members by the board chairman utterly controlled elections by selecting the names that would appear on single slate ballots on which the boards invariably passed unanimous approval. With one exception, the Georgia HSAs permit no one but existing board members to vote in these "elections."

The composition of all six Georgia HSAs totally or grossly disregarded representation of low and moderate income persons, women and the handicapped.[2/] At early public hearings, when members of these groups complained of exclusion from the process, the complaints were politely heard and routinely disregarded. And all during this time many consumer slots on the boards were filled by persons who were patently indirect providers.

In addition there was a full panoply of traditional barriers to meaningful participation by disenfranchised consumer interests. Medical professionals dominated board and committee meetings, and mystified the issues and solutions in jargon and technical language. The staffs of health planners were of little assistance to consumers because they had been enlisted directly from provider organizations and were likely to return to provider organizations if they left the HSA, and thus they ultimately depended upon the community of providers for success in their careers. Meetings of powerful committees and task forces were inadequately publicized and reported. No HSA established subarea councils, despite a clearly expressed public desire for them, because this would have forced a sharing of board power with consumer interests.

The Georgia HSAs have literally defied the public involvement mandate of the Planning Act. Public hearings are advertised by miniscule announcements buried in the legal notices section of newspapers. Attendance, since not encouraged, is poor; one HSA turned out one person at two meetings and ten persons at a third meeting held on its designation application. Comments offered by those who do attend are not transcribed and are often summarized, abbreviated, or chopped up when the HSAs prepare their records of public comments for submission to HEW. Citizens who show up at HSA board and committee meetings are barred from participation, first by denial of the opportunity to enter into the discussion on the floor and second, by refusal to

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[2/] For example, on the East Central Georgia HSA 18% of the board members have low or moderate incomes (income of less than $15,000 annually) while 89% of the population of the HSA area have low or moderate incomes. Women comprise 51% of the population of the ECG HSA area, yet have only 19% of the representation of the board. In the State of Georgia 88% of the families have low and moderate incomes but these persons have only an average of 26% of the representation on HSA boards.

distribute copies of printed materials (staff reports, etc.), necessary to follow the course of the meeting. One of Georgia's HSAs held its meetings during working hours of weekdays; another cancelled its executive committee meeting due to an ice storm, but went ahead with its public hearing scheduled for the same evening.

The North Central Georgia HSA is undergoing a process of having its Health Service Plan adopted, a plan on which public comments were required by law, but on which public comment was in all ways prohibited. Only 35 copies of the 900 page document were made available in an area of almost 2 million people, who were in turn allowed a period of one week to read and comment on the document. The cost to photocopy the document was $90.00. The HSA has stated that once the Plan is accepted by HEW, then more copies will be available for "special interest groups" such as the poor and middle income citizens in the area.

The posture assumed by HEW as the regulating agency overseeing the HSAs has made it a partner in the hoax played out by the HSAs against all health care consumers. HEW has had the opportunity to make the Planning Act a useful tool for consumers and has chosen not to do so. It has utterly failed in the duties assigned it by Congress to promulgate regulations to implement the Planning Act by July, 1976, and has demonstrated that it has no intention of completing regulations by its year long string of broken promises made to the courts to have guidelines published.

In the absence of regulations HEW has been conducting monitoring activities purportedly guided by the terms of the Planning Act, but very often in clear disregard of these terms. Conducting non-critical reviews of HSA activities, HEW has admitted that it accepts the statistical compilations of HSAs without review and accepts statements from the HSA, without investigation, that its board composition is "broadly representative" as required by the Planning Act. In the process, HEW has designated HSAs for operation when HEW admitted it was in the dark about the income levels of consumer members, their organizational affiliations, by whom or what organization

they were nominated and whether their spouse's source of income relegates them to provider status. Review of HSA activities now amount to so much conjecture as to whether anyone on the board of an HSA might be representative of the low income sector of society, about whether 20% female representation of the board is adequate, and about whether any of the numerous public officials on the board might be serving in a position of responsibility for health care. Decisions as to whether each HSA board is representative of its community are based on some unarticulated feeling of HEW staff that the boards are or are not out of line with an assumption that if things were not as they should be, the community certainly would let it be known. Of course, when public comments at public hearings are not transcribed but instead transformed by the HSAs before they reach HEW, the message from the community has little chance of getting through. The greater problem, of course, is the fact that so little of the community even knows it is being represented by its HSA board. One HEW reviewer noted this, feeling a bit reluctant to approve of the HSA serving the area in which he lived since he knew he would not have been aware of the existence but for his job in reviewing it.

In defense of its failure to enforce the Planning Act, HEW excuses itself by asserting that the explicit terms of the Act require no more of it than it is now doing. It is so very plain that HEW is unwilling to read the clear intent of the Act that consumers be given the opportunity to determine the future of their health care. HEW's abdication to provider dominance can be corrected only by a clearly expressed mandate from Congress contained in these amendments to the Planning Act.

Faced with this seeming impenetrable array of provider forces and HEW apathy, the consumer groups have attempted to battle their way into some position of influence. The North Central Georgia HSA was forced into holding a series of public meetings after formation of the Community Health and Monitoring Project (CHAMP), an organization which has confronted the HSA and had limited success in forestalling rampant abuses in capital expenditure reviews. The Southeast Georgia HSA was forced

to approve a badly needed clinic in downtown Savannah after the Coastal Health Action Group (CHAG) was organized and attended a board meeting in mass. This group was also successful in placing several of its candidates on the HSA governing body through the only elective system of board selection in the state. These organizations should be nurtured so that their successes are the rule rather than the exception.

Finally, individual consumers representing low and moderate income persons, women and the handicapped filed a lawsuit in federal court in Atlanta, Georgia, seeking an injunction against HEW, the Governor and all six HSAs, requiring that the structure and operation of the HSAs be reformed to ensure their participation. Although the court action is still pending, the Governor and the six HSAs have been dismissed as defendants. This dismissal followed the decision of the Fifth Circuit Court of Appeals in Texas ACORN v. Texas Area Five HSAs, in which the court rendered consumer provisions of the Planning Act largely meaningless. Very simply the court ruled that "broadly representative" means whatever HEW says it means by regulation. And since HEW has refused, despite promises to the court, to issue regulations, the consumer provisions of the Act now stand virtually useless. In this vacuum an HSA board composed entirely of providers and bank presidents could legally get HEW approval.

The real tragedy of the lawsuit was that it had to be brought at all. The intent of the Planning Act has been flagrantly violated by the HSAs, and HEW, entrusted with implementation of the Act, has deliberately ignored the situation. As too often happens, the courts became the avenue of redress when the political process perverted the intention of Congress. And because the courts and HEW have largely forfeited their chance to give meaning to Congressional intent, Congress must now state clearly and strongly its commitment to effective public participation in health care planning.

My name is Martin Ellin. I am an attorney with the Atlanta Legal Aid Society, and offer testimony as a member of that organization and as a consumer interested in the functions of the Health Systems Agencies in Georgia.

Following is an assessment and evaluation of the state of medical care delivery in Georgia prepared with the assistance of doctors, attorneys, paralegals, health planners, paramedics and consumer recipients of health care. The findings and conclusions are alarming—routine medical attention, or any medical attention even in emergency situations, is virtually unattainable away from the large urban areas of the state. The attached documents present a discouragingly realistic account of the inaccessibility of medical services faced by the poor of Georgia, a crisis which HSAs have for the large part ignored.

The problem appears to be fourfold:

1. There are simply not enough doctors and medical clinics in non-urban areas. Those living in rural areas lack transportation to permit them access to urban medical centers.

2. Most doctors in rural areas do not accept Medicaid and charge prohibitive fees in advance for their services; the few doctors and hospitals that do accept Medicaid are overburdened. Individuals tend therefore to stay at home and suffer quietly, even with serious illnesses, figuring they simply will not succeed in being seen, should they venture out to seek medical treatment.

3. Even if patients do find a way to see a doctor and can pay his or the clinic's fee, these expenses leave little money remaining for prescribed medicine or medical aids.

4. The concentration of medical services in large metropolitan areas is continuing, or worsening, and there has been no effort by the HSAs to assess and to plan for the medical needs of the underserved.

The attached summaries of affidavits speak clearly and painfully.

SUMMARY OF AFFIDAVITS

1. Three week old B.D. was treated in the emergency room of the Medical Center of Central Georgia on December 14, 1977. B.D. was afflicted with a cough which was choking him. The examining physician diagnosed the child and described his illness as a cold in both lungs. The doctor prescribed some medicine and scheduled a return appointment.

B.D.'s mother returned to the hospital the following week with her child in a worsened condition. As a matter of routine, the desk clerk asked Mrs. D. if she had insurance or Medicaid. When the answer was "no" to both, the clerk demanded a $30 emergency room fee. Mrs. D., unaware that payment of the fee might be arranged after the child was seen rather than before, sat with the child in the waiting room as his condition grew still more serious. Eventually an unknown benefactor paid the fee. Two hours later, B.D. was seen.

The child was already dead.

2. In June of 1977, G.B. was working as a migrant laborer in Florida when he met two men who asked him to come to Johnston, South Carolina, to work in the peach harvest. G.B. agreed to their request and rode with them in the back of a truck to South Carolina, exact location unknown.

When it came to settling the wages that G.B. was to receive a dispute broke out. G.B. was put on a chain and dragged behind a truck, apparently to teach the other migrants involved in this recruiting trip a lesson. G.B. was in time discovered near the Georgia-South Carolina border and taken by the North Augusta-Belvadere Rescue Squad to the University Hospital for treatment of the extreme abrasions and lacerations he had received. The hospital examined him, determined that he was not in a "life-endangering" situation at that time, and refused to treat him. G.B., without funds, had nowhere else to go for treatment.

He was finally seen two weeks later, when he had infections all over his body and could barely move.

3. S.C. is a 20 year old mother of two, expecting a third child in May, and is the sole support of her family.

In Spring, 1977, in the last stage of her second pregnancy, she became ill. Family and friends called her obstetrician , who refused to see her. When her condition worsened, friends drove her to the emergency room at the closest Hill-Burton hospital. S.C. was admitted for the night and finally saw her doctor the following morning when he made his daily rounds. This was only the third time she had seen him during the entire pregnancy.

She has seen an obstretrician only once during her third pregnancy, for the few obstetricians who practice in her county work in a clinic which requires payment in advance. S.C. simply does not have the money.

4. S.C. was involved in an auto wreck in early November in Burke County, Georgia, and was taken by ambulance to the University Hospital in Augusta. This hospital is a Hill-Burton, "open door" facility, and therefore should not turn anyone away because of inability to pay, or throw them out once admitted if they still require treatment. S.C. was treated at University Hospital, but when his ninety days of Medicare coverage were about to expire his relatives were advised to immediately remove S.C. from the hospital, since he would then be unable to pay.

S.C. was still unconscious and in intensive care when the hospital recommended that he be discharged.

Mr. Chairman, members of the Committee, I am Melissa F. Greene, a paralegal with Georgia Legal Services Programs, and a member of the steering committee of the Coastal Health Action Group (CHAG). CHAG is a grass-roots consumer organization in Savannah, Georgia, which has in the past year addressed local issues which threatened to increase health costs for our area or which presented barriers to people in need of medical services.

Throughout 1977, up to the present, CHAG members have tried to affect the decisions of the Southeast Georgia Health Systems Agency, first as outsiders and community advocates, then as committee members, and presently as elected members of the HSA Board of Directors. We believe in regional health planning as a logical and necessary process, but we believe it is too important to be dominated by health care providers. We have attempted to participate in cisions made by our HSA, but have found that our successes depended upon our political maneuvering and ad hoc strategizing. The Planning Act provides no simple way for individuals or consumer groups to influence the HSAs and no institutional safeguards to protect and develop their contributions if they win access to the system.

I will describe my group's involvement with the Southeast Georgia HSA to illustrate first, that consumers are becoming aware of the Planning Act and are eager to learn about and participate in health care planning, and second, that consumers still must engage in political battles to overcome traditional provider control of the planning process.

Southeast Georgia Health Systems, Inc. (SEGHS) is unique among HSAs in Georgia in that it is an open membership corporation in which members have voting rights in the annual elections of board members. To run for a board position or to vote for board members, a resident of the 24-county

service area must be at least 18 years of age and must complete an application for HSA corporation membership. This system stands in contrast to that of Georgia's other five HSAs in which only existing board members are given votes in the selection of their successors. The experiences I wish to relate to you demonstrate that despite the open membership mechanism, the SEGHSA has failed to publicize its existence and its activities adequately and has placed obstacles before consumers' attempts to participate.

SEGHSA was incorporated in September 1975 and had its first election in October of that year, but most consumers did not even become aware of the existence of the HSA for nearly a year. Though half a dozen Legal Services employes voted in the HSA election of October 1976, the election was still dominated by provider groups.

The first issue to arouse consumer interest involved HSA refusal to act on a proposal which we believed might greatly benefit poor communities. In October 1976, the HSA was asked to request designation by HEW of downtown Savannah as a "medically underserved area." A public health clinic had been proposed by United Way health council members and federal funding for the clinic depended in part on the HSA's requesting this designation. The Legal Services supported this proposal because we believed that downtown Savannah desperately needed the public health clinic.[1/] Of the 37 physicians serving the downtown area, 13 were nearing retirement age, and only 5 were accepting new Medicaid patients. The private downtown hospital was planning to relocate south of town which would leave the downtown residents without an emergency room and an out-patient facility; and the only indigent care clinic in the city was over-crowded and takes half an hour to reach by bus from downtown.

1/ Of the 52,000 residents of downtown Savannah, 22,000 have incomes below the poverty level. 12.4% of downtown residents are elderly.

The HSA Project Review Committee voted to recommend that the HSA seek that designation, but on February 17th the HSA Executive Committee rejected the Review Committee's recommendation. Medical Society members serving on the Executive Committee questioned the need for the clinic and stated that the Medical Society could address the needs of the downtown population.

On March 3, 1977, the Project Review Committee again voted for designation. On March 9th, the Executive Committee again rejected the committee's recommendation. Representatives of Georgia Legal Services presented affidavits from downtown residents and heads of agencies appealing to the Executive Committee to reconsider. The Committee appointed a special task force, chaired by one of the private practicing physicians opposing the clinic, to investigate further.

On April 21, 1977, the Executive Committee met to consider this task force's recommendation that designation NOT be sought for downtown Savannah. On that date, the newly formed Coastal Health Action Group attended the Executive Committee meeting to show widespread community support for the proposed clinic. An attorney for the group read HEW's guidelines to the Executive Committee, pointed out that all evidence indicated that downtown Savannah did indeed fall within the definition of a "medically underserved area," and recommended that the HSA seek designation. In response to the group's overwhelming presence, the Executive Committee voted to seek HEW designation and funding for the clinic. Had our consumer group not intervened, the provider-dominated board would have allowed the proposal to be tabled.

A similar strategy of public education and mobilization was relied upon by the Coastal Health Action Group to influence the HSA's decision regarding a request by Candler General Hospital for HSA approval of 65 additional beds for its proposed new facility. Candler had received approval from the State Comprehensive Health Planning Agency to build the new facility with a capacity for 275 beds, but the Candler staff determined that the new building needed a greater capacity. Candler was leaving

downtown Savannah in order to relocate five blocks from the county-subsidized hospital, Memorial Medical Center. The proposed move would leave downtown, with its high proportion of poor, black, elderly, and disabled residents, without a hospital or emergency room. The relocation next door to Memorial would jeopardize the financial stability of the county hospital and would duplicate services and equipment provided by Memorial, while offering the most expensive private rooms in the region.

CHAG publicly opposed Candler's move and their request for additional beds. Statements made by CHAG members generated constant controversy through the newspapers and television news, and sparked a new kind of dialogue between the hospitals: Memorial proposed merger to Candler. For a short while it appeared that consumer intervention might force the provider community to consider service-oriented, cost-containment-oriented alternatives, but Candler declined the merger proposal.

The HSA held a public hearing on the bed issue in response to the high level of public interest. The high turnout of 140 people was an unprecedented attendance at a public hearing. The HSA staff had thoroughly researched the bed issue and concluded that (1) there was a predicted surplus of over 140 beds by 1985 without the 65 additional beds; and (2) Candler's proposal showed only superficial cooperation with other area facilities and included too much duplication of services and equipment. The HSA board voted to deny Candler's request. This denial was the first time the HSA denied any application submitted to them. The denial exemplifies the kind of responsible, well-researched, and cost-containing decisions reached when the HSA board is made to feel the presence of an informed and watchful public.

The Southeast Georgia HSA on these two occasions was responsive to demonstrated public opinion. Unfortunately, this is not enough: HSAs do not adequately publicize their meetings and upcoming reviews, and few consumer groups have the resources, time, or staff to monitor and publicize every action of the local

HSA. The mobilization of 60 to 100 people to react to HSA issues can be effective, but it is unfair to demand that consumers constantly demonstrate mass support for their ideas, while the providers, by virtue of their organization and familiarity with the process, easily dominate the decision-making. Much more valuable in the long run will be attainment by consumers of positions of genuine power and responsibility within the HSAs. The HSAs need to make themselves accessible to consumers and to public comment by publicizing their activities (by means other than announcements buried among the legal notice sections of local newspapers), by developing viable means of surveying the needs of the service area populations, and by de-mystifying their processes for their consumer board and committee members.

In the summer of 1977, CHAG decided it would be more practical to find a way to participate in the next HSA board election than to rely on its ability to discover and rally around specific critical issues. The HSA election was scheduled for October 20th, and there were 25 vacancies to be filled.

Although the criteria to become a voting member, as mentioned, are not rigorous, they are practically secret. The HSA publishes the mandatory notices of election but does little and ineffective outreach to area residents. Solicitation materials for making nominations were sent to all corporate members, units of city and county government, and health-related agencies and organizations, but the vast majority of the consumer population remained unaware that an election was taking place. The applications for corporate membership were available only from the HSA office in Brunswick, Georgia. The election was held one evening only in Jesup, a ninety minute drive from Savannah which is the largest city in the service area. No transportation to or from the election site was provided, and there was no proxy voting or voting by mail permitted. The latter policy alone excluded the poor, the handicapped, and the elderly from participating in the election.

The Coastal Health Action Group performed the functions which ought to have been undertaken, but were not, by the HSA. CHAG publicized the election by publishing press releases, appearing on radio and television, and distributing membership applications and sample ballots. To the extent that our budget allowed, we provided transportation. We nominated 2 consumers and 2 providers for board positions, and we publicly endorsed 15 others. The corporate membership rolls swelled dramatically in the months prior to the election and over 350 corporate members attended the election in Jesup. All candidates nominated or endorsed by CHAG were elected.

The election experience made it woefully clear that provider-dominated HSAs have neither the inclination nor desire to promote consumer involvement in HSA operations. Had CHAG not been involved and publicized the election by means designed to attract participation, I have no doubt that the same provider-oriented board would have been elected. And I am confident that had this not been the only open board selection system in Georgia we would not have succeeded on the urban Health Center and Candler Hospital issues much less elected some of our own people to the board.

Having won seats on the HSA board and on task force committees, consumers were next confronted with almost impossible odds against their meaningful involvement in HSA business. Given only sketchy orientation and inundated with reams of technical and statistical information, they were expected to negotiate with provider members on equal terms. The board members elected in October, 1977, were given a day and a half orientation in November and were asked to vote on the final draft of the Health Systems Plan in December. Said one new consumer representative, "I didn't even understand some of the words. I wouldn't know what to disagree with. It was sort of a rubber stamp."

The consumer committee and board members contacted by CHAG describe their

HSA experience, almost without exception, as a period of unrelieved confusion. Kenneth Hindman, a year-long member of a committee stated, "The consumers naturally realize their lack of expertise, and the resultant fear of making the wrong decision makes it hard for the plan to mean anything. The pressure to create a product by a certain deadline, relayed to members by the staff, make committee members even more insecure. The staff typically reacted to these fears or to requests for further study by stressing the changeability of the plan over time and the necessity of submitting something. With the consumers lost and some of the providers acting like they'd been appointed to some honorary post, like Rotarians, the staff seemed to be the only ones with any stake in the plan."

In practice the HSA staff described the process, introduced the priorities, and in some cases overrode the desires of the committee members. In July of 1977, the staff working with the Secondary/Tertiary Committee despaired of getting action from the committee and announced that a consultant had been hired from out of state for $5,000 to complete the committee's work. And when the committee did arrive at its own decisions the decisions were almost never based upon surveys of consumer needs or desires but were instead reached in a vacuum.

Conclusion

The Coastal Health Action Group proposes that Congress adopt amendments to the Planning Act requiring that at least 10% of each HSA budget be designated for consumer board education and public participation. And since any system of board education will be ineffective in the context of a provider-dominated board (or even a provider-dominated education program), it is critical that Congress state more clearly its commitment to the representation of low and moderate income persons, women and the handicapped on HSA governing bodies which have in reality not been "broadly representative" of community interests.

Testimony of Anne A. Smart

Regarding the Mid-Louisiana HSA

My name is Anne A. Smart. I reside in Baton Rouge, Louisiana. I am here to testify relative to my concern that poor folks like myself are finding it virtually impossible to gain membership status on the boards of HSAs. I am a welfare and Medicaid recipient. I also serve as a member of the Legal Services Corporation Clients Council and National Welfare Rights Organization and am Chairperson of the Louisiana Hunger Coalition.

The mandates of 93-641, that the governing body of a Health Systems Agency be composed of a majority of consumers "who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care*, are not being met. The mid-Louisiana HSA, which sits in Baton Rouge, is typical in that it ignores this mandate, and its decisions typify the poor decisions that are made by non-representative governing bodies. The immediate consequence is that the federal health care priorities of serving the underserved and cost containment are not being met.

The mid-Louisiana HSA's Health Service Area II covers 24 parishes. The governing body is composed of 16 consumer and 14 provider members. A recent Bureau of Social Science Research, Inc. study reveals that, in 1976, nearly 40% of all families in HSA II had family incomes of less than $10,000.** Nearly 60% of all

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* 42 USC § 3001-1(b)(3)(C)(i)

** Only 1 board member's family income is less than $10,000.

families had incomes below $15,000. Only one other board member has a family income below $15,000. Although 60% of the families in the Service Area have incomes below $15,000, less than 13% of its board reflects this "economic" characteristic. No other board member has been selected by the poor to represent their interests. Furthermore, this HSA's executive committee, which makes most of the important HSA decisions, is composed of fifteen board members. Of these 15, 9 are consumers and of those 9, only 1 has an income below $15,000. However, 60% of our population have incomes below that amount.

This HSA has obviously attempted to adhere to the "racial and geographic" mandates of 93-641 because 7 consumers are black and there is an equitable split between metropolitan and non-metropolitan characteristics. Economic characteristics were not considered, however, so once again the poor are denied access to decision-making power for themselves or their chosen representatives.

Their absence has lead to the drafting of an HSP with no consideration of the significant problems of the medically underserved population of the area. I have studied the HSP, with the help of a health planner, to look for its strength and weakness.* The demographics, however, outline the true socio-economic situation in Louisiana's HSA II.

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*I understand the statistical base is inadequate.

Part I

Demographics

The Mid-Louisiana Health Service Area is composed of a population that is 8% over age 64, 40% rural, 30% black and 25% below the poverty line. Sixty percent of the black population and 40% of the white population live in housing built before 1950. Eleven percent of white dwellings are overcrowded and 4% lack plumbing. Thirty percent of black dwellings are overcrowded and 30% lack plumbing. (1970 census reported in the draft health systems plan.) More than 80% of the persons receiving public assistance in this area are black and 80% of the unemployed are black (Louisiana State Department of Health and Human Resources and Employment Security, 1975). In the private economy, in the three standard metropolitan statistical areas of Baton Rouge, Lake Charles and Lafayette 56% of the white workers are employed in white collar jobs, 41% blue collar jobs and 3% in service jobs. Of the blacks who are employed in these areas, 21% are in white collar jobs, 55% are in blue collar jobs and 21% in service jobs. (Equal Employment Opportunity Commission Report, 1973).

Part II

Health Status of the People in Mid-Louisiana Health Service Area

The aggregate infant mortality rate is 16% for whites and 27% for blacks of which the white neo-natal mortality rate is 12%

and the black is 19%. The post neo-natal mortality balance which relates to nutrition, shelter and so forth of children after 28 days of life is 4% for whites and 8% for blacks. A comparison of black teenage/births to white shows 31 for each thousand live births to 19 white (1970 census material and State Department of Health and Human Resources material reported in the draft of health systems plan).

PART III

Data Sources

From the foregoing it is obvious that the health systems plan of the Mid-Louisiana HSA exhibits carefully selected data on the characteristics of the population. This data was compiled by Federal and State agencies, local governments, and provider oriented national organizations. Relevant materials developed locally appear to be non-existent in the plan and material available from federal sources such as the Office of Civil Rights, the Economic Opportunity Commission and state counterparts is not included.

PART IV

Priority Goals and Objectives

In creating its priority goals and objectives, the draft of the health systems plan ignores both the above data and also information generally available from local media and special studies of the area. The priority goals and objectives, while in some cases specifying sex, age and parish as target populations for priority treatment, make no mention of blacks or of the poor.

The exclusion of black and poor people from access and quality health care in Louisiana is as well known and systematic

as is their exclusion from decent housing, decent food at competitive prices in their neighborhoods and jobs. As a matter of course, black and poor people are directed to the state run charity hospital system emergency rooms and clinics which are staffed by virtually unsupervised interns and residents. They cannot go to private physicians for ambulatory care as the white middle and upper classes can.

In addition, rural parishes continue to be excluded from health systems development, especially in terms of personnel distribution.

PART V

Types of Information Left Out of the Draft Health Systems Plan

The HSP data base only touches upon the significant problems of the medically underserved of the area. More relevant data, easily accessible, was not utilized.

Cane Curtain

For instance, more than 100,000 people live and work on sugar cane plantations in the triangle formed by the cities of New Orleans, Alexandria, and Abbeyville. The bulk of this population behind the "cane curtain" is in the Mid-Louisiana health service area and is almost exclusively black.

These impoverished plantation workers have few cars. However, more than 40% of these people have to travel over 5 miles to see a physician for hospital or clinic outpatient care because the large majority of physicians in private and community hospitals in the immediate area will not treat blacks or medicaid patients. 70% must travel to a charity hospital for inpatient services which may be 100 miles away. More than 50% cannot afford prescribed medicines or nutritious

food. 70% have serious rat problems and 73% have serious insect problems.

The workers and the families are sprayed regularly with pesticides used for the cane field as their housing is situated adjacent to those fields. The pesticides are also ingested with the goods grown in family gardens, if in fact the vegetables survive the cane pesticides. For the families living near the sugar mill, added hazards are chemicals used in the refining process. The bayous, where fresh fish formerly provided a meaningful dietary supplement,are now so dirty that the fish supply is diminished and those which are caught are contaminated and inedible. (Interview with Sister Ann Catherine Bizalion and testimony of the Southern Mutual Health Association presented at the NHI Field Hearing before the Subcommittee on Health of the Committee of Ways and Means, House of Representatives, May 20-21, 1976).

These relevant data typifying health and occupational hazards is nowhere found in the draft HSP. Criticisms of the board by low income representatives indicate that the control of the board is dominated by too many physicians, and that the consumers are professional or managerial type persons - basically high income consumers. The meetings are sporadic, and in places which are inaccessible by public transportation. Publication of board meetings in newspapers of general circulation is inadequate to reach the poor. The black community newspapers are locally printed and distributed. Also, Louisiana has the highest illiteracy rate in this country.

When a primary HSA concern is that emergency rooms in Baton Rouge are not open to middle class people who don't have

their Blue Cross cards readily available, the general attitude of the health care provider community in the area is insensitive to the real needs of poor people. There are examples of charity patients who are not able to get a clinic appointment for post surgery checkups for a year and a half after their surgery. This indicates the desperate need for expanded services for the poor. This also indicates a need for physicians who are willing and able to serve the poor. The system as it is established now has an adequate supply of physicians for the wealthy and middle class but not many who are willing to serve the poor people. For many people it is 20 or 30 miles to the closest facility which will serve them because the physicians are not inclined to serve black and poor clients and to work towards some sort of transportation network for the rural areas.

A community leader in the area, Father McKnight of the Southern Cooperative Development Association, has had his own television program. But, in spite of his high visibility and concern for the encouragement of rural medical practices, he had never been solicited or even formally apprised of the existence of the health systems agency.

Fran Bussie of the State AFL-CIO stated that the role offered to organized labor on the Mid-Louisiana HSA had nothing to do with participation in decision-making. Labor was only offered some sort of vague non-board committee assignment. Non-governing body members can only play a passive role in the rubber stamp process. The AFL-CIO interest in redistributing personnel to low-income and low-density areas, and for establishing proven reorganization methods such as health maintenance organizations appears contrary to the interests

of the clique of physicians running the board and the agency.

There is a high rate of industrial accidents in the area, in part due to a lack of preventive maintenance of equipment. This should be a top priority for the agency, but it is not. The clouds of chlorine gas that frequently spew over the Baton Rouge area from bursting pipelines are a hazard to the entire community, not only the plant workers.

The agency did not follow up on Bussie's suggestion to invite the leadership of the major Central Labor Committees in the area to be on the board. Without labor representation the priority goals will continue to ignore the needs of working people which are embodied in the law.

PART VI

The Consequences of Improper Board Composition

Non-representativeness of the Mid-Louisiana HSA board has led to the development of meaningless priority goals which appear in the draft health systems plan. The goals and objectives do not deal with the problem of the existing health system and the present health status in the area. The problems of the dual system of health care in Louisiana as a whole, and in the Mid-Louisiana health service area in particular, are reflected both in the composition of the HSA board and in the manner of selection of representatives to that board, although membership loosely defined on the agency board is open to all residents in the area.

Although the bylaws of this HSA provide that the members of the corporation elect the board and the executive committee, the poor have been unable to gain access to this process. The nominating committee proposed its own slate of candidates and

this HSA held its annual election at a time and place inaccessible to us. Consequently we were thwarted in our efforts to gain elected positions.

The inattention to the needs of the medically underserved (which are highly particular in that they are the black population, the working poor, and persons living in rural areas) can only be cured by the inclusion of these groups in a meaningful decision-making capacity. This must include membership on the executive committee, nominating committee, and project review committee. Later, when the resource development monies are available, this must include representation on the resource development committee.

The current draft plan could not possibly have included its priority goals, which are irrelevant to the needs of the medically underserved in the area, if there were poor persons in positions of power to closely examine it. Apparently, only the poor and persons directly accountable to them can recognize the urgency and priority of their need.

References to a desired goal of not more than a thirty minute personal travel distance for primary care would not exist if there were poor people in the decision-making bodies to point out that the poor don't have cars in the area, and that public transportation is unavailable. They could also point out that the expansion of segregated, non-Medicaid/Medicare hospitals does not benefit black and poor people and certainly does nothing to solve their needs.

The amendments to prohibit self-selection are a needed change, but will do little to open HSA boards if nominating committees continue to screen out low-income persons or their chosen advocates. Nominating committees must be controlled by

law and should not be allowed to thwart the efforts of the poor to seek status in various capacities on the board. The Mid-Louisiana HSA was responsible for thwarting my ability to gain board status. That would be bearable if some other poor folks had succeeded where I've failed. They have not.

Certification/Decertification

As long as a dual system of health care continues to exist and be reflected in the boards of directors and executive committees of the health systems agencies and the state health coordinating councils, the certificate of need process will simply tighten the current monopoly control by the wealthy for themselves. Future health care systems development will continue to deny quality care to anyone else.

It does not hurt to point out that the cynicism of the streets and bayous toward congressional procrastination concerning a universal national health care system is seen as "coddling the alligators." In direct regard to certificate of need the cynicism is expressed as "we got the need, they get the money." There is great concern in Louisiana that certificate of need will result in a continuation of the 1122 review process which, in Louisiana, has the consequence of diminishing public sector health care delivery. The number of beds in the charity hospitals have been reduced and more private rooms are being developed in the fancy segregated private hospitals. In fact, the dissatisfaction with the present system on the part of consumers here is so great that the prestigious annual Louisiana poll for 1977 showed that 52% of those responding wanted "socialized medicine" and 61% wanted a national health insurance system of universal

comprehensive coverage.

Furthermore, the bill as proposed makes no meaningful provision for the hundreds of persons thrown out of work in the closing of a hospital, although the care taken for those involved financially is so great and reparations are generous to an extreme. In addition, the disregard shown for the low paid workers in hospitals stands in sharp contrast to the congressional reluctance to tell physicians where and how to practice. An ironic aspect of this latter comparison is that while physicians are educated at enormous public expense and should therefore be considered national resources and placed where they are needed, they constitute a tiny portion of the health work force. In fact, perhaps the public and private investment in health care development will be better served if institutional investors and suppliers do not have their investment risks removed. The obvious consequence would be to compel them to be more cautious in their investment practices.

In summary, I strongly urge this Congress to force the inclusion of more low income consumers in this health planning process. Low income consumers are confronted with inadequacies in today's health care system that current HSA board members cannot relate to. Our input is valuable, warranted and will make a significant difference.

TESTIMONY OF WILLIE MAY THOMPSON

I, Willie May Thompson, declare as follows:

1. I am a resident of Oakland, California. I am employed by the Oakland Public Schools as a Human Relations Assistant. I am the current Chairperson of the Governing Body of the Alameda County-Contra Costa County Health Systems Agency.

2. Prior to my involvement with this two county, Area 5, HSA, I was a member of the Comprehensive Health Planning Agency and was the Alameda County representative to the regional board of that organization.

3. In light of my experience serving on these various health planning agencies I believe that consumer involvement in the health planning process is, at once, vitally necessary and very difficult to achieve.

It is necessary because the consumer is the one who has to pay the cost of health care in this country. While representatives of the health care industry possess considerable technical expertise in the delivery of health care, their obvious interest in continued and increased spending on health care services often conflicts with the consumer interest in controlling costs and unnecessary spending, and in insuring that health care is accessible.

Consumer involvement is difficult to achieve, particularly for consumers with low incomes, because consumers are intimidated by providers, often deferring to what the consumer believes is a superior knowledge and understanding of the problems, because the consumer becomes confused by the complex and rapidly changing rules

and regulations governing health planning, and because of the active discouragement or lack of adequate support and encouragement from federal, state and local officials.

For instance, the lack of adequate support staff in the health planning process virtually assures that there will not be significant consumer input in reviewing hospital applications for Certificates of Need.

The Alameda and Contra Costa County Counsels Offices have ruled that members of the county boards of supervisors must be included as consumer representatives on the governing board of our two county HSA.

This leaves only two consumer positions on the governing board of the HSA for persons who are not members of the Alameda or Contra Costa County Board of Supervisors.

Nevertheless, significant consumer input could come from our 35 member sub-area councils and from county task forces which were initially established to increase consumer participation. However, any member of these organizations cannot serve on a Certificate of Need review panel unless he or she has attended two training sessions. Without sufficient staff and other forms of support it is simply impossible to involve significant numbers of consumers, particularly low-income consumers, in two training sessions. Thus, there is not sufficient consumer input in the Certificate of Need review process.

Any amendments to the health planning laws must insure that HSA's employ adequate staff to support and encourage consumer

involvement.

The health planning process will fail in its mission if more grass roots involvement is not generated and if politicizing is allowed to prevail. In the absence of consumer input health care providers can apply individual political pressure to frustrate attempts to provide accessible quality care while controlling the provision of unnecessary services.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on the 28 day of January, 1978, at Oakland, California.

Willie Mae Thompson

WILLIE MAY THOMPSON

STATEMENT REGARDING THE NEED
FOR CONSUMER RESOURCE STAFF

We are consumer members of Review Committee I of the Health Systems Agency of Dade-Monroe County, Florida. The basic function of our committee is to recommend to our Board the approval or disapproval of applications for Certificates of Need.

It is our opinion that we could better fulfill our responsibilities as committee members if we were provided with technical assistance regarding specific proposals and continuing education regarding national health issues and consumer issues. This function could be performed by either a full-time or a part-time HSA staff person with this assignment.

Such a staff person would be valuable for several reasons. First, the issues raised in the proposals before us are often complex and encompass areas with which the provider committee members are well-informed, although we are not. Technical assistance from a staff person specifically geared towards the level of awareness of the consumer members would assist us in becoming well-informed as well, so that we could better contribute to the decision-making process.

Second, specific proposals should ideally be considered in the framework of national health policy and trends--an area with which provider members are again often well-informed and consumer members are not. Continuing education regarding such issues could

assist us in assessing proposals in a broader context.

Finally, the concerns of the consumer are often very different from those of the provider. A consumer staff person could serve the function of sensitizing the consumers as to these differing concerns so that they could be properly voiced in the decision-making process.

This statement is not intended as criticism of our HSA or its staff for this vacuum--we merely feel that the addition of a consumer staff person would make us better committee members and consequently make our HSA a better one.

Francisco Olazabol
Corinne Dunn
Marcia K. Cypen

HEALTH CARE ACCESS: IF YOU'RE BLACK* STAY BACK

by Sylvia Drew Ivie**

---A black, unemployed domestic worker sought entrance to a private hospital in Latta, South Carolina, to deliver her baby. The hospital refused to admit her because she had no admitting physician and childbirth was not considered an emergency. The county ambulance attendant took the woman to 20 doctors; none would order the woman admitted. Seven hours after their ride began, the ambulance attendant delivered the baby himself.

---Off-reservation Indians in Phoenix, Arizona, are routinely denied admission to a private facility's emergency room because of the existence of a nearby Indian Health Service facility. The Indian Health Service refuses service, however, because its contract with HEW for care of Indians is limited to the reservation population. The city Indians return home without care.

---In Phoenix, Arizona, a Mexican-American teenager and his white friend, unconscious after a car-train collision, were taken to a private hospital. The Anglo was admitted to the hospital; the Mexican-American was transferred to a county facility an hour's drive away.

---Brown, Spanish-speaking women seeking admission to an El Paso, Texas, hospital facility to deliver babies are routinely presumed to be illegal aliens and taken by ambulance across the border to Juarez to deliver in a free Mexican clinic.

---Black, low-income maternity patients seeking emergency service in Holly Springs, Mississippi, often deliver their babies by themselves in the hospital parking lot because the hospital won't admit them without a private physician.

As Congress prepares to debate proposals for National Health Insurance versus National Health Service (government as insurer versus government as provider of health care), it is imperative that the impact of race on the current patterns of health care delivery be understood. The above examples, recently reported by Legal Services lawyers, demonstrate that racism remains a significant barrier to quality care. They raise an important issue of whether the private health sector should be relied upon

*Brown, Native American, Asian...

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to voluntarily serve low-income minorities if a National Health Insurance program is enacted.

A pervasive pattern of racial discrimination in health care has been recently documented by the Congressional Budget Office study entitled "Health Differentials Between White and Nonwhite Americans." The report found that nonwhites are less healthy than whites, that they get less health care, and that the care they do get may be less effective.[1/] Financial barriers, scarcity of available resources, and racial discrimination all contribute to this result.

Financial Barriers

One-third of the nation's population with income below the poverty line has no public or private medical insurance coverage.[2/] By definition, these people have no spare money, and as a result they are simply unable to purchase care. This group includes disproportionate numbers of minorities.

The federal medical insurance programs, Medicare and Medicaid, which promised to reduce financial barriers to some categories of people, do not provide equal assistance to whites and minorities. Medicare co-payment requirements place a greater program entry burden on those beneficiaries with lower incomes, a disproportionate number of whom are minorities. In the South, disparities in Medicare benefits between races are greater: whites received 55% more inpatient hospital care, 95% more payments for physicians' services, and more than 2-1/2 times the payment for extended care services than elderly blacks enrolled in Medicare.[3/]

A similar inequity of service is found in the Medicaid program. In 1974, the average Medicaid expenditure for nonwhites was $321; for whites $560, a 75% differential.[4/] Since Medicaid eligibility levels and benefits are determined by the states, the programs vary considerably. The states with higher percentages of minority populations tend to have more stringent eligibility requirements and to provide

ONE-THIRD OF THE NATION'S POPULATION WITH INCOME BELOW THE POVERTY LINE HAS NO PUBLIC OR PRIVATE MEDICAL INSURANCE COVERAGE.

fewer services. In addition, nearly a third of the total federal Medicaid expenditure is spent on long-term care, a system from which minorities have been intentionally or effectively excluded.[5/]

Geographic Barriers

The unavailability of physicians and facilities in rural and inner-city areas also has a disproportionate effect on minorities. The shortages in these areas are not fortuitous. Indeed, federal and state policies have significantly reinforced this trend.

Federal funds have been used to place hospitals in generally white, middle-class areas. As of March, 1964, for example, 104 hospitals and health facilities had been built with federal funds under the Hill-Burton Act; 84 of these facilities were built for "whites only;" 20 for "blacks only."[6/]

White physicians generally follow the hospital construction pattern and do not establish practices in rural or inner-

city areas. The number of minority physicians available to locate in these areas has been kept low by discrimination in admission to medical schools.[7] Discriminatory hospital staffing practices prevent minority physicians from admitting their patients to white facilities.[8]

The latest contribution to this pattern is relocation of inner-city hospitals and their staffs to new facilities in the suburbs. This raises nearly insurmountable access problems because of the distances involved and the fact that suburban transportation is sparse or nonexistent.[9] Federal or state health planning agencies can and must challenge these relocations because of their racially discriminatory impact on access.[10] To date, little is being done.

Medicaid and Race Discrimination

Even where providers and facilities are geographically available, access may still be denied as a result of the provider's or facility's refusal to participate in the Medicaid program. Hospitals built with

LOW-INCOME WHITES ARE MORE LIKELY TO RECEIVE CARE FROM PRIVATE PHYSICIANS THAN ARE ANY NONWHITES REGARDLESS OF INCOME.

federal funds are required by federal regulations to accept Medicare and Medicaid patients[11] and are prohibited from intentionally or effectively excluding patients on the basis of race.[12] Unfortunately, there is virtually no enforcement of these requirements.[13]

Some hospitals which "participate" in the Medicaid program avoid serving many minority recipients by requiring that patients be admitted by a physician with staff privileges. Minorities are less likely to have access to physician care at all, let alone care by one with staff privileges. The Congressional Budget Office study cited above found that low-income whites are more likely to receive care from private physicians than are any nonwhites regardless of income.[14]

Many physicians refuse to treat Medicaid patients, disproportionate numbers of whom are minority;[15] others will see all patients but treat them differently on the basis of race or source of payment.[16] While existing federal regulations are quite clear about government enforcement obligations with respect to hospitals,[17] HEW maintains that the decision by physicians to treat or not to treat minority or Medicaid patients, or to segregate or otherwise treat Medicare patients differently on account of race, is outside the perimeter of its nondiscrimination enforcement responsibility.[18]

Consequences of Lack of Access

As a result of the barriers to mainstream health care experienced in minority communities, minorities suffer increased morbidity and mortality.[19] Even without change in the other causes of poor health, such as inadequate housing and nutrition, better access to care could reduce the incidence of illness and lower death rates.[20] Because the system is not geared to provide comprehensive care to minorities, there is insufficient attention to problems such as hypertension, narcotic drug abuse, psychiatric problems, kidney disease,

diabetes, and tuberculosis, all of which occur with greater frequency among minorities.[21] Moreover, since mainstream hospitals and physicians deny access to minority communities, minorities are forced to rely on other types of health services. These include public hospitals, outpatient clinics, self-treatment with non-prescription drugs, and community "healers." These alternatives provide care which is fragmented, low quality, and indifferent to or unable to cope with the particular medical needs of minority communities.

Patient dumping, in which patients are cursorily treated at a private facility and then sent to a public hospital, contributes to patterns of omission of services, hasty or inaccurate diagnoses, and failure to treat. Because of inadequate financing and governmental neglect, the public hospital sector is often unable to provide the level of care available at a private facility. This is evidenced by lower staff-patient ratios, obsolete equipment, language and cultural barriers due to lack of bilingual staff,[22] long waiting periods for service, and discourteous treatment by an overextended staff.

Corrective Measures

The practical politics of the impending national health program debate dictates immediate attention to these problems of inadequate access and fragmented and inferior quality care for minorities. The following recommendations are given as the first steps in resolving these problems, regardless of whether the country opts for National Health Insurance or a National Health Service:

1. Increase the number of physicians and other health providers willing and financially able to treat minorities and Medicaid recipients.

Minority physicians mainly treat patients who are minority.[23] Their practices are twice as likely to be in primary care fields as are white physicians' practices.[24] The meager number of minority doctors as a whole, however, prevents minority communities from receiving an equitable share of health resources. Within the black community, for example, there is one black physician for every 4,298 black people. This compares to a national average of one physician for every 649 people.[25]

Assuring reimbursement of nurse practitioners and paramedical personnel in local clinics should also reduce the medical personnel shortages experienced in minority communities. The recently-passed Rural Health Clinic Services Act (P.L. 95-210) authorizes the reimbursement of rural health clinic services, including those of physician assistants and nurse practitioners in states recognizing those medical care providers, even if the services are not provided under the direct supervision of a physician.

2. Reduce the financial barriers to participation in Medicaid by equalizing benefits and levels of eligibility in all states through mandatory minimal federal standards.

3. Secure governmental enforcement of Title VI of the 1964 Civil Rights Act in health services.

This law prohibits discrimination in all federally assisted programs and activities. Enforcement should be directed toward hospital and nursing home admission practices and physician inpatient and outpatient services.

HEW must compel collection of health statistics by race and ethnicity by hospitals, nursing homes, state agencies, and health planning bodies to facilitate this enforcement.

4. Secure governmental enforcement of charitable obligations of tax-exempt hospitals.

5. Secure governmental enforcement of Hill-Burton Community Service regulations.

These regulation require federally-assisted hospitals to admit Medicare and Medicaid patients.

6. Recognize the limited promise of reducing financial barriers as a means of securing services for unpopular minority groups.

Proposals for national health services as opposed to national health insurance must be seriously considered in light of the pervasive failure of the private sector to make health care accessible to minority groups.

7. Expand health service programs targeted at special groups or at special health problems.

The Congressional Budget Office study found that most government-provided health service programs, targeted at specific areas or specific medical problems, are serving nonwhites more effectively than financing programs that depend on the private sector.[26] Those efforts can be expanded by more funding and by refining efforts designed to reach nonwhites with particular health problems. As long as racial discrimination remains a bar to care, such organized service delivery programs must exist to be the "resources of last resort" for minorities and the poor.

8. Facilitate efforts of community groups to define and control implementation of solutions for their local health concerns.

Paul Cornely, a black physician and past President of the American Public Health Association, recently wrote:

> ...[T]he malady of racism does exist...[I]t is endemic and appears in a variety of sub-clinical and clinical forms.... Of all groups in our society, the poor Black woman may be the most perceptive of life's realities. She knows full well that an integrated facility is better than an all Black one because all too often she and her children have been the victims of oppression in public hospitals and clinics. She knows that when it is all Black, the physical facility tends to become obsolete and may even have been condemned; personnel and supplies are in short supply, and Black providers are paid less than whites. Her perception and intuition transcend educational levels.[27]

Such women and men in black and brown, Asian and Native American communities across the country must be allowed to put their knowledge to work not only to secure access but to compel delivery of a better quality of care in all facets of the health delivery system. Their historic exclusion from all health planning processes is in large measure responsible for the fact that the country moves today toward major health reform measures in total ignorance of the appalling state of health care services available to this country's minority populations.

FOOTNOTES

1. "Health Differentials Between White and Nonwhite Americans," Congressional Budget Office, September 1977, at 37.

2. Karen Davis, "Achievements and Problems of Medicaid," Public Health Reports 91:309 (July-August 1976).

3. See, Karen Davis, "Equal Treatment and Unequal Benefits: The Medicare Program," Milbank Memorial Fund Quarterly 53:449 (Fall 1975).

4. National Center for Social Statistics, Social and Rehabilitation Service, HEW, Washington, D.C. 1977, cited in "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 17.

5. In 1974, for example, minorities represented only 5% of all patients in nursing homes, although 9% of all persons over 65 are nonwhite, and elderly nonwhites average more than twice as many bed disability days as do elderly whites. "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 19.

   Access is barred to minorities by inability to pay for nursing home care and by racially discriminatory admission and referral patterns. Because of the disproportionate poverty of minority persons, refusal by a facility to participate in Medicaid makes many ineligible for admission. Even where the home takes Medicaid patients, pronounced racial discrimination keeps minority numbers low. See, e.g., "Evaluation of Nursing Homes in Philadelphia and Allegheny Counties: Services for Minorities," Pennsylvania Department of Health, June 1977.

6. H. Morais, The History of the Negro in Medicine, Publishers Co., NY, 1967. Regulations permitting construction of hospitals for racially separate population groups were not held unconstitutional until 1964.

7. Howard and Meharry Medical Schools have produced over 90% of the nation's black physicians. See, J. Blackwell, The Black Community, Dodd, Mead & Co., NY, 1975, at 127. In 1948, 14 southern states signed an interstate compact to support Meharry Medical College in Nashville, Tennessee, for students barred from admission to medical schools within their borders. P. Murray, States' Laws on Race and Color, Women's Division of Christian Service, Methodist Church, Cincinnati, 1951.

8. Discriminatory staff admission practices have been documented widely outside the South. See, D. Reitzes, Negroes and Medicine, Harvard U. Press, Cambridge, 1958, detailing staff participation in hospitals in Philadelphia, Boston, Brooklyn, Chicago, Detroit, and Los Angeles.

9. N.A.A.C.P. v. The Wilmington Medical Center, 436 F.Supp. 1194 (D. Del. 1977), challenging the removal of a downtown facility to a distant suburban area.

10. Section 1122 of the Social Security Act, 42 USC §1320 (1972) requires governmental approval of health facility construction if the facility intends to obtain reimbursement for such construction under federal reimbursement programs such as Medicaid and Medicare. The National Health Planning and Resources Development Act, 42 USC §300k, prohibits unapproved capital expenditures. Both review processes must include consideration of the impact of construction on minorities in accordance with the mandate of Title VI of the 1964 Civil Rights Act, 42 USC §2000(d).

11. See, Cook v. Ochsner, 61 F.R.D. 354 (E.D. La. 1972), holding that Hill-Burton facilities could not reject patients because of their source of payment (Medicaid) without violating their statutory duty to provide "a community service" in return for the federal construction funds received under the Hill-Burton Act. HEW later implemented this ruling by regulation. See, 45 CFR §53.113(d)(2)(i)(B), and 39 Federal Register 31767 (August 1974).

12. Title VI of the 1964 Civil Rights Act, 42 USC §2000(d), prohibits exclusion from participation in or denial of benefits of any program or activity receiving federal financial assistance on the basis of race. HEW regulations carrying out the statutory mandate prohibit use of methods of administration which have the effect of subjecting persons to discrimination because of race, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to members of particular minority groups. 45 CFR §80.3(b)(2). The same regulations prohibit a recipient of federal funds from using racially different admissions policies by use of contractual or other arrangements. 45 CFR §80.3(b).

13. HEW Division of Facilities Development personnel recently informed the author and several other Legal Service lawyers that Hill-Burton complaints are being filed at a rate of one a day throughout the country. Ten percent of those allege violation of the community service regulations. To date, only one community service complaint has been resolved. There are only eight people in the national office responsible for review of Hill-Burton complaints.

    With respect to Title VI enforcement in the health and social service area, HEW indicated that only 19 people are available for the entire nation under its operating plan for fiscal year 1977. 41 Federal Register 41776 (September 23, 1976).

14. "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 12.

15. See, Cook v. Ochsner, supra, note 11, which raises the issue of the refusal of private physicians to treat Medicaid patients.

16. See, Walker v. Pierce, 560 F.2d (4th Cir. 1977), upholding the right of physicians to require Medicaid patients with a certain number of children

to voluntarily submit to sterilization following delivery or to otherwise refuse them medical services. Several suits have recently been filed challenging segregated physicians' waiting rooms in North Carolina, Florida, and Mississippi.

17. See notes 11 and 12 supra.

18. See, "The Federal Civil Rights Enforcement Effort, 1974," U.S. Commission on Civil Rights, November 1975, at 118.

19. Measures of life expectancy, infant mortality, maternal deaths, fetal deaths, and deaths among young children show a vast difference between whites and nonwhites. See, U.S. Bureau of the Census, "Statistical Abstract of the U.S., 1976," at 64; National Center for Health Statistics, HEW, "Summary Report: Final Mortality Statistics, 1973," Table 3.

Bed disability days are highest among low-income families in nonwhite communities. See, "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 4.

20. See, e.g., B.Y. Iba, J.D. Niswander, and L. Woodville, "Relation of Prenatal Care to Birth Weights, Major Malformations, and Newborn Deaths of American Indians," Health Services Reports 88:697 (October 1973); "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 7, showing reductions in infant mortality between 1965 and 1975 after the advent of Medicaid and Medicare.

21. "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 5.

22. "Ineffective communications between the provider and the consumer reduce most interactions to impersonal and inadequate episodes of one-way dialogues. The provider speaks in the name of objective reality and efficiency. The low income, urban, Mexican-American family responds by staying away." M. Cadena and M. Trevino, "Utilization Barriers to Maternal-Child Health Care Programs of the Urban, Low Income, Mexican Family: Implications for a National Health Policy," paper presented at APHA conference, November 1977, at 14.

23. M. Koleda and J. Craig, "Minority Physician Practice Patterns and Access to Health Care Services," J. National Health Planning Assoc. 2:1 (November-December 1976); L.C. Gray, "The Geographic and Functional Distribution of Black Physicians," American J. Public Health 67:519 (June 1977).

24. "Characteristics of Black Physicians in the United States, 1975," DHEW (HRA).

25. T. Thompson, "Curbing the Black Physician Manpower Shortage," J. Medical Education 49:944 (October 1974).

26. "Health Differentials Between White and Nonwhite Americans," supra, note 1, at 35.

27. P.B. Cornely, "Racism: The Ever-Present Hidden Barrier to Health in Our Society," American J. Public Health 66:246 (March 1976).

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December 14, 1977

Dr. Suzanne Dandoy, Director
Department of Health Services
1740 West Adams
Phoenix, Arizona 85007

Re: Good Samaritan Hospital,
Major Modification Project,
HF 77-20

Dear Dr. Dandoy:

This letter is submitted to you in connection with your responsibilities under R9-9-33. Please consider this letter an administrative appeal from the decision of the Central Arizona Health Systems Agency on November 16, 1977, adopting Findings with respect to Good Samaritan Hospital's application for a certificate of need to undertake major modification of its facilities at 1033 East McDowell Road, Phoenix, Arizona.

Our firm appeared on behalf of and represented the Sun Valley Council, United Auto Workers, throughout the certificate of need procedure in connection with the above-mentioned application. This letter is sent on behalf of the Council.

As explained more fully herein, lobbying activities and ex parte communication between officers, directors and employees of Samaritan Health Service (SHS) and others acting on its behalf, and members of the CAHSA Board have so tainted and influenced the final decision in

this matter, that it is legally incumbent on you to reject the Findings as submitted and return the application to CAHSA for reconsideration with specific instructions to assure against improper influence being placed upon the Board.

The certificate of need process permits an extended period of time for CAHSA staff, representatives of the applicant and concerned consumers to meet on a regular basis for the purpose of making a full and complete record. Furthermore, there is an opportunity for a public hearing, in this case, forty hours of testimony, at which time a citizen review committee is charged with the responsibility of taking testimony to further clarify issues. The CAHSA Board also conducts a public hearing at which time additional comments are presented directly to the Board.

In the case of the Good Samaritan application, however, SHS through persons acting on its behalf, carried on an extensive lobbying campaign outside the hearing process. The purpose of the hearing procedure is to enable the CAHSA Board and committees to review the complex factual background underlying the application in an objective fashion and in an environment in which facts and testimony can be questioned and examined. Ex parte communication as carried on by SHS provided neither an opportunity for careful scrutiny of statements made nor an opportunity for rebuttal. Furthermore, improper pressure and influence may be attempted under such circumstances. As shown in the section below, courts when confronted with situations similar to this, uniformly invalidate agency action which has been subject to such improper influence.

SUMMARY OF IMPROPER INFLUENCE
BY SHS REPRESENTATIVES

Based upon our review and investigation of the lobbying efforts carried on by SHS, we have identified the following examples of ex parte communication:

1. Contacts by business or professional friends of CAHSA Board members made at the request of SHS;

2. Lobbying campaign by physicians with privileges at Good Samaritan Hospital and other health professionals instigated at the request of SHS;

3. SHS orchestrated communications directed at CAHSA Board members from certain labor organizations, the Kidney Foundation and other groups;

4. Prior to the first public hearing, SHS sponsored a series of cocktail parties to "acquaint" CAHSA Board members with the application;

5. Persons connected with state and federal offices made contacts with CAHSA Board members at the request of SHS;

6. An inflammatory letter dated October 19, 1977, from Dr. George H. Mertz (enclosed) to certain CAHSA Board members subsequent to the public hearings and prior to the final vote by the CAHSA Board,

7. A letter dated October 17, 1977, from Stephen Morris to Howard Adams (enclosed) stating that it would be the policy of SHS to carry on ex parte communication with CAHSA Board members; and

8. CAHSA Board members were given a one-sided tour of the hospital by SHS between the time of the public hearings and the date arranged for CAHSA Board final consideration of the application.

The nature and character of the lobbying program carried on by SHS was not restricted to matters in the record nor was it solely informational in nature. Contacts of that type would have been permissible under existing CAHSA policy. The lobbying activities of SHS, however, go beyond the bounds of propriety and legality.

The foregoing examples are those that we have been able to discover. Undoubtedly there were many more contacts of which we are unaware. Because of these improper contacts, it is necessary that you disapprove the Findings of CAHSA and send this matter back for reconsideration under circumstances not permitting the improper influence described above.

EX PARTE COMMUNICATION TO A PUBLIC BODY ACTING IN A QUASI-JUDICIAL CAPACITY WILL RENDER A DECISION VOID

When CAHSA acts in connection with the issuance of a certificate of need it acts in a quasi-judicial capacity. Quasi-judicial functions can be performed by administrative bodies which are not quasi-judicial. The Arizona Supreme Court has described a "judicial" act as an action which is the result of judgment or discretion and is based upon evidence received at a hearing provided by law. Magma Copper Company v. Arizona State Tax Commission, 67 Ariz. 77, 191 P.2d 169, 175 (1948). Also, under the Arizona Administrative Procedure Act, A.R.S. Section 41-1001 et seq., the granting of a certificate of need is considered a contested case, A.R.S. Section 41-1001(2), requiring notice, a hearing, the right to appeal, and other traditional hallmarks of an adjudicative proceeding.

It is well established that ex parte communications to members of administrative bodies operating in a quasi-judicial capacity are entirely improper and will result in the action of that administrative body being voided. For example, in Sangamon Valley Television Corp. v. U.S., 269 F.2d 221 (D.C. Cir. 1959), the court remanded a case to the Federal Communications Commission when it appeared that ex parte presentations were made to various members of the Commission and letters were written to them which did not go into the public record, giving those opposing views set forth in the letters no opportunity to question their content. The court held that private approaches to members of the Commission vitiated its action and the proceeding must be re-opened.

In Jarrott v. Scrivner, 225 F. Supp. 827 (D.D.C. 1964), the court found that secret and ex parte communications made to a board of adjustment in connection with a decision to

permit construction of an embassy in a predominantly residential area voided the decision. The court found that it was unnecessary to find intentional wrongdoing and that the contacts made were "of such a character that it may reasonably be inferred that they did impair, consciously or unconsciously, independence of judgment." The court concluded that the board could not rehear the matter in a fair and impartial manner and directed that a new board should hear the appeal.

Finally, in English v. City of Long Beach, 217 P.2d 22 (1950), the California Supreme Court held that the action of a civil service board in taking evidence outside of the hearing and presence of interested parties constituted a denial of a fair hearing. In directing the civil service board to conduct a new hearing, the court stated that "the fact that there may be substantial and properly introduced evidence which supports the board's ruling is immaterial."

As these cases and others indicate, the CAHSA Board has an obligation to give all interested participants a fair and impartial hearing before reaching its decision. This requires that Board members avoid ex parte contacts and base their decision only upon evidence in the record. To give consideration to evidence outside the record is to act beyond the scope of their authority.

SUMMARY

Based upon the ex parte and secret contacts described above, it is likely that if a court were to consider this matter it would conclude that the CAHSA Board could not under any circumstances hear the Good Samaritan application and that an entirely new board must be constituted. Although this position would be legally defensible, it is not our desire to be punitive or obstructionist in any way and we therefore do not urge such action on your part.

In light of all the circumstances, in fairness to consumers, the applicant and to preserve the integrity of the health planning process, we recommend that:

1. The Department of Health Services conduct a complete and thorough investigation to determine the extent of all lobbying contacts made in connection with the Good Samaritan project;

2. You do not accept the Findings and return the matter to CAHSA for reconsideration; and

3. Any further consideration of the application be conducted in accordance with procedures prohibiting all ex parte communication.

We urge your immediate attention to this matter.

Sincerely,

Bruce Meyerson

BM:elb

Enclosures

cc: Don Alampi, Sun Valley Council, United Auto Workers
Ted Williams
Milton Gan
Regional Office, Department of H.E.W.
Stephen Morris

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October 7, 1977

Harry P. Cain, Ph.D., Director
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Health Resource Administration
Public Health Service
H.E.W.
Hyattsville, Maryland 20782

David Tatel, Esq.
Director, Office of Civil Rights
Department of Health Education and Welfare
330 Independence Ave.
Washington, D.C.

Re: Denial of access to care to blacks and Medicaid recipients in Memphis, Tennessee by Saint Joseph's East and Methodist Central Hospitals

Gentleman:

On July 22, 1977, Ms: Ammie Thomas, a 21-year old black resident of Memphis, Tenn. sought emergency health care at Saint Joseph's East Hospital, Methodist Central Hospital and the City of Memphis Hospital. This complaint deals with the refusal of service by St. Joseph's East and Methodist Central Hospital because the patient was a Medicaid recipient. Both hospitals are non-profit facilities participating in federally funded programs. Both have a duty to operate their facilities in a racially non-discriminatory manner. Rejection of Medicaid recipients as a matter of policy in the City of Memphis is racially discriminatory in intent and in effect in violation of federal law.

A. Rejection by St. Joseph Hospital

At 9:00 P.M. on July 22, 1977, Ammie Thomas was taken by her mother, Mrs. Elizabeth Turner, to the emergency room of St. Joseph's East. St. Joseph's East is a non-profit church-affiliated hospital built in Memphis in 1974. It is certified to take Medicare patients, 42 U.S.C. §1395, and has participated in other federally-funded programs

such as an Emergency Medical Services planning grant.

Ms. Thomas had been suffering for two days with severe pain in her side accompanied by some vaginal bleeding. She was examined by house staff who diagnosed the presence of ruptured ectopic pregnancy (a pregnancy in which the fetus is lodged in the fallopian tubes, a condition causing extreme pain and potentially threatening the life of the mother). Ms. Thomas had no private physician but was eligible for Medicaid. The hospital staff informed her that the hospital did not take Medicaid patients. A letter was typed giving the preliminary diagnosis and referring the patient to the City of Memphis Hospital, the only entirely publicly-financed hospital facility in the city.

B. Rejection by Methodist Central Hospital

Because the public hospital is overcrowded and understaffed, Mrs. Turner declined to take her daughter to that facility. Instead, she took her to the Methodist Central Hospital, a large, non-profit facility, built with Hill-Burton funds and certified to take Medicare patients. She was seen in the emergency room, told that the hospital did not take Medicaid patients, and was referred again to the City of Memphis Hospital.

Mrs. Turner then took her daughter to the City of Memphis Hospital emergency room. She was informed that they would see her but only after they had treated a number of cases that were more serious in nature than hers. After 3 hours of waiting in extreme pain, Ms. Thomas was taken back to Methodist Central by her mother at 1 A.M..

The staff person with whom they spoke on re-entry to Methodist told Ms. Thomas "that she was a stupid girl, that they had told her to go to the City Hospital, and why was she back here again?" Ms. Thomas explained that she was in severe pain and could not get help there. The staff person repeated that the hospital did not take Medicaid patients, at least not for "female problems" which is what she said Ms. Thomas had.

At this point Mrs. Turner called her employer, a woman for whom she worked as a domestic servant. The employer spoke with a staff person and Ms. Thomas was thereafter admitted at 3 A.M., treated and discharged the following day. (Admission and discharge records are attached hereto as Exhibit I.)

The refusal by both St. Joseph's and Methodist Hospital to treat Ms. Thomas constituted a violation of her constitutional, statutory and regulatory rights to treatment in those facilities.

C. Violation of Duties Under Title VI of the 1964 Civil Rights Act

The refusal by both hospitals to take Medicaid patients constituted a violation of Title VI of the 1964 Civil Rights Act, 42 U.S.C. §2000(d), which prohibits exclusion from participation in or denial of benefits of any program or activity receiving federal financial assistance on the basis of race.

Regulations issued by the Department of Health, Education and Welfare pursuant to Title VI state that a recipient of federal funds

> "may not...utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of race or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race. 45 C.F.R. §80.3(b)(2).

The same regulations provide that

> "a recipient of federal funds may not, directly or through contractual or other arrangements, on the ground of race, treat an individual differently from others in determinig whether he satisfies any admission, eligibility or other requirements or conditions which individuals must meet in order to be provided any service, or other benefit provided under the program... 45 C.F.R. §80.3(b).

St. Joseph's Hospital and Methodist Hospital both participate in the federal Medicare program providing governmental reimbursement for medical care of persons 65 or older who also receive Social Security (Title II) benefits. See 42 U.S.C. §1395. Statistics gathered by the Health Services Administration of H.E.W. for 1974 indicate that 10% of St. Joseph's East's patients were Medicare eligibles, as were 18% of Methodist Central's patients. Methodist received nearly 6 million dollars in Medicare reimbursement in 1975.

Both hospitals participated in a 1967 planning grant under the federally-funded Emergency Medical Services Program, P.L. 93-154, a program designed to improve institutional emergency care.

Methodist Hospital received federal construction funds under the Hill-Burton Act, 42 U.S.C. §291, in both 1966 and 1968. The grants totalled over a million dollars.

Receipt of benefits under each of these programs, i.e. Medicare, Hill-Burton, and Emergency Medical Services brings the hospitals under the prohibitions of Title VI of the 1964 Civil Rights Act. Receipt of such funds necessitates implementation of all hospital programs in a non-discriminatory manner. The "program or activities" referred to in Title VI and "the program" in the regulations under Title VI are to be broadly construed to encompass all hospital activities, not just those activities specifically receiving federal funds. The policy of excluding Medicaid patients results in "an exclusion from participation in or denial of benefits of... program[s] or activity[ies] receiving federal financial assistance." 42 U.S.C. §2000(d).

It results in this denial "on the basis of race" because the area of service of both hospitals includes a large black population. The number of black Medicaid eligibles is even greater than the proportion of minorities in the county as a whole.

The area of service of the hospitals in question is approximately 40% black. The median family income in the area is $8,671. Because of the low income of the population as a whole, approximately 90,000 people are eligible for Medicaid, 42 U.S.C. §1395. Because the per capita income of blacks is less in the area than that of whites, blacks are eligible in even greater numbers for Medicaid than they are represented in the population as a whole.

Methodist Central and St. Joseph's Hospitals intentionally and effectively discriminate against blacks on the basis of race by refusing to take Medicaid patients because the majority of Medicaid recipients are black. CF Shannon v. HUD, 436 F2d 809 (3rd Cir. 1970); Lau v. Nichols, 414 U.S. 563 (1974).

Because Methodist and the parent facility of St. Joseph historically discriminated against black patients regardless of income or source of payment, they now have an affirmative duty to correct that pattern of admission. See 45 C.F.R. §80.3(b)(6)(i). Admission of Medicaid patients would in large part satisfy this mandate.

D. Violation of Community Service Duty under the Hill-Burton Act

Methodist Hospital has been a recipient of Hill-Burton Construction Funds under 42 U.S.C. §291 et seq. The Hospital is required as such a recipient to give assurances that

> ...the facility or portion thereof to be constructed or modernized [would] be made available to all persons residing in the territorial area of the applicant.
> 42 U.S.C. §291c(e)(1)(1970).

H.E.W. regulations implementing this section of the statute require that the applicant hospital give assurances that

> The facility will furnish a community service; and
>
> All portions and services of the entire facility for the construction or modernization of which, or in connection with which, aid under the Act is sought will be available without discrimination on the basis of creed. 42 C.F.R. §53.113(a)(1) & (2)

In 1973 a United States District Court for the Eastern District of Louisiana in the case of Cook v. Ochsner Foundation, 61 F.R.D. 354 (E.D.La 1972) interpreted these regulations judicially for the first time. The court held that "community" included Medicaid recipients and directed the Secretary of H.E.W. to require

> ...that Hill-Burton recipients participate in the Medicaid program and refrain from excluding persons on the basis that they are recipients of Medicaid from Hill-Burton hospitals. See 39 F.R. 31766 (Aug. 1974).

Accordingly, the Secretary added a regulation stating that in order to comply with the community service assurance each Hill-Burton assisted facility must

> ...Make administrative arrangements with those federal government programs, such as Medicare and Medicaid, to the extent that the applicant is entitled to reimbursement at reasonable cost under a formula established in accordance with applicable federal law.
>
> 42 C.F.R. §53.113(d)(2)(i)(B), 39 Fed. Reg. 31767 (Aug. 1974).

Methodist Hospital has historically failed to seek certification as a Medicaid provider. Its failure to take Medicaid and other indigent patients has previously been the subject of complaint to HEW. See e.g., letter of the Director of HEW Health Care Facilities, February 18, 1975, attached hereto as Exhibit II, reflecting complaint and indicating that Methodist Hospital did not take Medicaid patients and did not have state Medicaid certification. On information and belief Methodist is still not certified as a Medicaid provider.

Its failure to participate in the Medicaid program constitutes a blatant violation of its community service obligation.

The H.E.W. Hill-Burton regulations also recite the non-discriminatory requirements of Title VI of the 1964 Civil Rights Act:

> Attention is called to the requirement of Title VI of the Civil Rights Act of 1974 (42 U.S.C. §2000d; 78 Stat. 252) which provides that no person in the United States shall, on the ground of race... be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.
>
> 42 C.F.R. §53.113

The failure to take Medicaid patients violates Title VI requirements as discussed in paragraph C above and thus violates the non-discriminatory mandate of the Hill-Burton regulations.

E. Relief Sought

Attorneys for the complainant seek compliance reviews of both St. Joseph East and Methodist Central under 42 U.S.C. §291(c), 300P(2)(c), and 42 U.S.C. §2000(d). The complainant and her attorneys are willing to assist the Department in any way in conducting these requested reviews. Should our allegations be substantiated, we request imposition of appropriate sanctions, including but not limited to a freeze on all further federal funding and referral to the U.S. Department of Justice for enforcement litigation.

Respectfully submitted,

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cc: Joseph Califano, Secretary, DHEW.
Robert Derzon, Administrator H.C.F.A.

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH
P. O. BOX 90'
HARRISBURG 17120

LEONARD BACHMAN, M.D.
SECRETARY OF HEALTH

March 21, 1977

Mr. William R. LePage
Executive Director
Central Pennsylvania Health
Systems Agency
400 Market Street
Lewisburg, Pennsylvania 17837

Dear Mr. ~~LePage~~: Bill

I am writing to you with reference to my letter of February 25, 1977 in which I explained the reasons for my very reluctant action in recommending approval of the proposal of American Medical Affiliates, Incorporated for the construction of a 180 bed nursing home in DuBois, Clearfield County. You will recall that my reluctance stemmed from the fact that the Board of Directors of the Central Pennsylvania Health Systems Agency had recommended that the proposal be disapproved and that the Designated State Planning Agency was unable to support that recommendation.

In response to the very strong sentiments expressed to me by members of the Board during my visit on March 9, 1977, the staff of the Department of Health's Division of Need Review has once again thoroughly reviewed the entire file on the project and has again been unable to find any documentary evidence which would persuade me that the DPA could, in fact, have supported the disapproval recommendation. Quite to the contrary, in fact, the latest report of Licensure Survey of Clear Haven Nursing Home by the Health Department's Division of Long Term Care, which was completed on January 7, 1977 indicates that no serious deficiencies were found to exist in the area of direct patient care. In addition, representatives of the Department of Public Welfare also visited Clear Haven on January 5, 1977 and have expressed in writing their satisfaction with the type of care being provided to patients who had been moved to Clear Haven from other long term care facilities. I am enclosing a copy of the Survey Report as well as the Department of Welfare's letter for your information.

However, since comments repeatedly made by CPHSA Board members alleging poor quality care are valued by the Health Department I have discussed this matter with Mr. Richard Zarin, Director of the Office of Quality Assurance. He is sending me all reports, correspondence, etc. relative to the Clearfield facility since the January survey. He assures me that his office is carefully monitoring the institution.

Again, thank you for the "warm" reception at the HSA meeting in Lamar. I was disheartened by the poor public turnout for comments on your application but I was very much encouraged by the thoroughness with which your board members examine state decisions and transmittal of those decisions.

I commend those members of your board who are concerned with quality of care. I must reiterate that the 1122 process only indirectly pays attention to this most important component of health care and health. If your Board wishes to pursue 'quality of care' vigorously albeit indirectly through the 1122 process I recommend their particular attention to the standard dealing with 'adequacy of staffing.'

In closing I repeat that the Pennsylvania Department of Health is most definitely concerned with quality of care and is doing everything feasible to insure that it is maintained at a high level.

Sincerely,

Denis J. Lucey III, M.D.
Commissioner
Office of Planning and Development

Enclosures

HSA SURVEY DATA

Name of HSA Central Arizona HSA

Health Service Area Maricopa, Pinal, Gila Counties and San Carlos Res.

Status of Designation Conditional

Is the Governing Body representative? No

Nature of representativeness disparity No consumers with median family incomes under $10,000; only 1 consumer with income under $15,000 out of 17 consumers. Most recently the HSA has begun no longer even requesting information on family income.

Is the Governing Body self-perpetuating? No

Method of selection A nominating committee is selected in the Fall of each year. It is composed of 3 consumers, 2 providers, and 1 representative of Gila/Pinal Counties. A slate is prepared in "accordance" with Public Law 93-641. A letter is then sent to the membership informing them of the slate. If members wish to nominate others, the members submit letters with the names of their nominees and the nominees' approval. The names of the new nominees are included on the ballot and a short biography is prepared on each.

HSA SURVEY DATA

Name of HSA HSA of South Florida

Health Service Area Florida Health Service Area IX

Status of Designation Conditional

Is the Governing Body representative? No

Nature of representativeness disparity 14 out of 21 consumers on the governing body have incomes of $25,000 or more; only 3 have incomes less than $15,000. 14 of the consumers on the governing body are men.

Is the Governing Body self-perpetuating? No

Method of selection The general membership elects the governing body during annual elections with the exception of some members who are ex-officio members with full voting privileges. Examples include the President of the Public Health Trust and the Dean of the Medical School at the University of Miami. Any resident of Dade or Monroe Counties may apply for individual membership. Membership is approved at the annual meeting of the general membership. In addition, health-related organizations can apply for membership and can appoint two voting members, preferably a consumer and a provider.

HSA SURVEY DATA

Name of HSA New Mexico Health Systems Agency

Health Service Area New Mexico excluding Navajo reservation

Status of Designation Conditional

Is the Governing Body representative? No

Nature of representativeness disparity 1 consumer out of 13 with a median family income under $15,000. 12 of the 13 consumers have incomes of $15,000 or more. No consumers over the age of 65.

Is the Governing Body self-perpetuating? No

Method of selection Entire governing body is appointed by the governor.

HSA SURVEY DATA

Name of HSA Metropolitan Health Planning Corporation

Health Service Area Cleveland Metropolitan Area

Status of Designation Conditional

Is the Governing Body representative? No

Nature of representativeness disparity Only 1 consumer out of 16 has a family income under the median income in the health service area. 12 of the 16 consumers are men.

Is the Governing Body self-perpetuating? No

Method of selection 9 consumer members are appointed by local government officials or bodies (county commissioners, mayor, federal coordinating agency); the remaining 7 are chosen by the board after being nominated by a nominating committee composed exclusively of representatives of government officials and providers.

HSA SURVEY DATA

Name of HSA Oklahoma Health Systems Agency

Health Service Area Oklahoma

Status of Designation Conditional

Is the Governing Body representative? No

Nature of representativeness disparity 12 of the 16 consumer members have incomes of $15,000 or more. This compares to the 1975 median family income of $12,400 in the health service area. 13 of the 16 consumers are men.

Is the Governing Body self-perpetuating? No

Method of selection Entire governing body is selected by the governor.

HSA SURVEY DATA

Name of HSA Utah Health Systems Agency

Health Service Area Utah excluding Navajo Reservation

Status of Designation Conditional

Is the Governing Body representative? No

Nature of representativeness disparity 13 of the 15 consumers have family incomes greater than $15,000. Only 2 consumers have family incomes less than $10,000.

Is the Governing Body self-perpetuating? No

Method of selection The Utah HSA is a public regional planning body created by state statute. It has a Governing Board which is appointed by the Governor and confirmed by the State Senate. The Governing Board, which is composed of a majority of elected officials, appoints the governing body (Health Planning Council).

Mr. ROGERS. Thank you very much.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Certainly I feel that we have had some very articulate young men and women here. I think Mr. Mitchell has been an excellent witness.

As it happens I have spent a great deal of my life in the practice of medicine. My oath, the oath of Hippocrates, stated that I would treat all patients. I believe that it behooves every doctor who is worthy of the name to do likewise, so long as he is physically capable.

I regret very much to hear of Mr. Mitchell's story of how people have been turned away because of lack of funds and so on. Over the years, because I come from a rural community, I know that there are not as many doctors as we should have and I also know that in certain areas of the cities, ghetto areas, a similar situation exists. Because of this we have tried to pair these two areas, ghetto and rural areas, to provide health care for the two.

And with the Chairman we have improved the national health scholarship program. We thought we improved the national health scholarship plan in order to provide services to these people, health care services. We did that so that physicians would go into deprived areas such as yours. That was the purpose of it. But I have not found many of them on the line of battle and I regret that very much.

I think that the OMB asked for $60,000,000 this year for the National Health Service Corps. Of course, it takes a little time for this but physicians could help. I do not know why they have not been sent into your areas to be of assistance.

I think some of them might have been swallowed up by the Public Health Service. I do not know just where they have been sent. Perhaps they are used as statisticians or for other reasons.

Our purpose in increasing the funding was to help areas such as yours. Personally, I deeply regret that the program has not been as effective as we had wanted it to be. Furthermore, the scholarships have been concentrated largely in two of our universities here in Washington, both of which over the years have had many physicians who just stayed here.

Once they get Potomac fever and they stay here for a few years I am afraid they don't go to the boondocks where I came from, or to the ghetto areas.

Anyway, we are trying to help. The chairman has been extremely helpful and supportive of this concept of helping the underserved areas. I will continue to do so.

Furthermore, I think you should have representation on HSA's. There is also no question that funding of this segregated hospital is in violation of the law, if it is funded. I do not believe that it will be. It seems to me it would be in violation of the law and the guidelines.

Oschner, of course, is a specialty group. I would also like to see them too take more of the patients of different groups. I do not want to be critical of them, but they are highly specialized and highly technical as is Joslyn, a diabetic clinic, and so on. I make no apologies for them.

The chairman is out right now. I suppose he will be back in a minute. If you have any questions you would like to ask me, go ahead.

Mr. PRESSEL. Dr. Carter, if I could address for just a moment the meaning of the testimony that you have heard. We are not coming to the committee asking you to police every hospital in this country. What we are asking for is greater access to answer the problems that we face. That access on behalf of women, on behalf of the disabled, on behalf of blacks, on behalf of poor people has too often been denied.

Mr. CARTER. I want to tell you right now that if it is left up to me there will not be one denied. In the years I practiced medicine, after I got my feet on the ground, none was denied as long as I was physically able.

I will admit a few times at 3 o'clock in the morning I might have turned over and gone to sleep, and I regret that, but I was not physically able to go on sometimes or did not feel that I was. Thank you.

Thank you, Mr. Chairman.

Mr. ROGERS. Well, your testimony has been helpful. I do think the committee in its basic law tried to provide for consumers. We said there must be a majority on the HSA board or up to 60 percent. Now that is a pretty good representation. So, the law is there which permits it. We will have to see what is happening.

Also, I am not sure that the HSA is going to be able to come in and change delivery patterns immediately. In other words, this law may not give us all the remedies we need for the health care system. It simply is to try to plan for the future.

As Dr. Carter mentioned, we have passed other laws for instance to try to do something, like critically underserved areas where we have the National Service Corp. That designation does not have to depend on HSA under that law. So that is not dependant on getting a designation.

I think they plan to send out some 1,700 doctors in this coming fiscal year into critically short areas which will help solve the problem. But at least there is a mechanism to begin to get into the critical areas.

Mr. CARTER. Are you familiar with any of the players on the New Orleans Saints team.

Mr. HENDERSON. I have seen them on television.

Mr. CARTER. Do you remember the name Elois Grooms?

Mr. HENDERSON. Yes.

Mr. CARTER. When you go back ask him who delivered him, and all his brothers and sisters.

Mr. HENDERSON. I never paid for a ticket to the New Orleans Saints and a lot of people have regretted that they have paid for their tickets.

I just want to say the HSA's are now in a position where they need some real guidance on what to do when we have an application, when we have evidence of discrimination. I would hope you could come up with some realistic guidance.

Ms. GREENE. We understand that the HSA's obviously cannot be the panacea for every health care problem. We are here, though, because we believe in the concept of the HSA and we support needed amendments. What is painful for us is to see the structure has been set up in such a way that the health system is not changing at all.

Mr. ROGERS. Of course, the President did not sign the law until 1975. They still have not put out the guidelines. We have to get on to them about that. They were supposed to be out in 1976. They are just now beginning to get them out. There are only nine fully designated HSA's in America. That is only nine.

We are still in the developmental stage. Now these conditionally designated, where you find that they are all providers and no consumers, that is a ground for not approving them. We are going to have the inspector general's office look into this situation.

We appreciate your bringing to our attention your concerns and we share these concerns and we are going to try to see what can be done.

Mr. MITCHELL. Mr. Chairman, I would like to thank you and the members of this committee for allowing me to come before you. I think I am kind of something different from what you have been having up here because I am a person from the community.

I would like to also express to you that I have been in the HEW regional office several times trying to find out about different programs. I have been tied up with the school problem in my country and I walk on crutches. They would send me to seven or eight places and I never could get to the right place to get somebody I want to talk to about the problem.

In my mind, HEW could stand an investigation in those regional offices because there are some things going on in these programs that I see that really need looking into.

Mr. ROGERS. We will be looking at that. I think you have done right in getting your lawyer, Mr. Pressel, here to help bring some of this to the attention of the proper people.

I am delighted to see you, and pleased to have you. We appreciate your coming. Thank you for your testimony today. Your testimony has been most helpful. We will consider seriously the points you have raised.

The committee will stand adjourned until 10 o'clock tomorrow morning.

[Whereupon at 5:55 p.m. the committee adjourned until 10 a.m., February 2, 1978.]

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